

## The Deprivation of Liberty Safeguards and The Mental Capacity Act 2005 Policy

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| 1        | 18/09/2017 | Para 3.2.7       | A requirement to share information about what the person needs to understand has been introduced.  | 18/09/2017  |
| 2        | 18/09/2017 | 3.2.9 and 3.2.15 | A new standard has been introduced to require a full recording of capacity assessments in relation to care plans.  | 18/09/2017  |
| 3        | 18/09/2017 | 3.3.3            | The guidance has been amended to emphasise the need to understand the world through the person's point of view when assessing best interest.                 | 18/09/2017  |
| 4        | 18/09/2017 | 3.13.23          | The Mental Health Act Administration team are now taking on the oversight of the DoLs process and informing the CQC.   | 18/09/2017  |
| 5        | 12/10/2017 | 3.6              | Advanced Decisions changed to Advance Decision. This was a typing error  | 12/10/2017  |
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## SUMMARY OF POLICY

This policy ensures that Solent NHS Trust has implemented processes and standards to ensure compliance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The policy requires staff to assess a person's mental capacity to make a particular decision in circumstances in which there are concerns about the person's ability to make the decision at the time it needs to be made. The Mental Capacity Act sets out how a person's capacity to make a decision must be assessed and this is described in the policy. If a person lacks capacity to make a decision then the decision is made for them by an attorney appointed under a lasting power of attorney or enduring power of attorney, by a deputy appointed by the Court of Protection or in line with a Court of Protection decision. If none of these exist then the decision maker must decide what is in their best interest. In doing so, they must seek to understand the decision from the person's point of view and make a decision that is right for them as an individual person. In carrying out any intervention the five guiding principles of the Act must be followed:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

If there is an unresolved dispute about a significant decision then the guidance in the policy should be followed and if it cannot be resolved then advice should be sought about whether an application to the Court of Protection is required.

If the intervention involves any form of restriction then it can only be carried out if it is necessary to prevent harm and it is a proportionate response to the likeliness of the harm occurring and the severity of the harm it is intended to prevent. If the restrictions amount to a deprivation of liberty then this must be authorised by a DoLs authorisation, under the Mental Health Act or via an application to the court of protection.

Each service must have a clear protocol that sets out where and when the following are recorded and checked:

1. capacity assessments,
2. best interest decisions
3. lasting powers of attorney or enduring power of attorneys
4. the existence of a court appointed deputy or a Court of Protection decision, and
5. any advance decisions to refuse treatment or advanced statements of wishes and feelings.

The key features are summarised in the table below.

| <b>Role/ Issue</b>                       | <b>Responsibilities</b>   | <b>In what situation</b>   |
|--|---|--|
| Decision maker for 'important decisions' | They are responsible for assessing capacity and best interests in relation to the specific issue at the specific time. This must be recorded using the form in this policy and appropriately recorded | When Solent NHS Trust is the lead agency for a particular intervention/ decision the consultant with responsibility for that aspect of the care will usually be the decision maker. However, if it is not the consultant it must be a registered |

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|   | on the electronic system. Those involved in carrying out the decision retain responsibility to do so in the best interests of the person and to raise concerns if they believe the person has regained capacity.  | practitioner. When Solent NHS Trust is not the lead agency they will not normally be the decision maker when the decision is consent to medical treatment   |
| Best Interest                                       | The best interest must be determined by the correct process. This will depend on the type of decision. It may be a 'simple decision', an 'important decision' or need a best interest meeting.  | In all situations where interventions are carried out with those who lack capacity to decide on the specific issue at the time.   |
| Independent Mental Health Advocate<br>IMCA          | The care team is responsible for referring to the IMCA service. The IMCA can see relevant records. The consultant in charge of the care is responsible for deciding what is relevant. The IMCA should be informed if they are seeing third party information that the service user is unaware of. The Confidentiality form should be completed (Appendix 3) | Refer when the service user is 'unbefriended' and a decision about serious medical treatment or longer term accommodation arranged by NHS is being considered. There is a discretionary power to refer in safeguarding situations or for care reviews.  |
| Review of capacity/<br>best interest                | Capacity assessments are time and decision specific. However, there may be an ongoing condition affecting capacity. Care teams must ensure that the assessments they act on remain valid.   | There is no set time scale to review assessments as this will depend on the circumstances of the case. However, capacity should be reviewed: <ul style="list-style-type: none"> <li>• whenever a care plan is being developed or reviewed,</li> <li>• If there is a significant change in clinical presentation,</li> <li>• at other relevant stages of the care planning process (specific teams will need to decide on this for their area of work), and</li> <li>• as particular decisions need to be made.</li> </ul> |
| Acts taken on behalf of a person who lacks capacity | To ensure they are in the best interest of the patient.   | All staff in all interventions. Staff members need to ensure that in situations where restraint is needed they do not go beyond the limits of section 5 and follow the restraint/ observation policies connected to their areas of work.  |
| Finances and assets of a person who lacks capacity  | Each team must have their own guidelines for when a person's money is spent on their behalf for necessary goods. Clear records and care planning must be kept. It should be considered if an  | Access to a person's property or assets can only be authorised by a lasting power of attorney, an order of the Court of Protection or, where a person's income is social security benefits, appointeeship. The Client Affairs Team and Portsmouth City  |

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|  | informal carer is better placed to undertake the role.   | Council can be contacted for more information (02392688199). Teams that are integrated with Portsmouth City Council can refer into the Client Affairs Team by following the pathway in appendix 7. For patient's residing in Southampton the adult social care team should be contacted on 02380 833003.                    |
| Lasting power of attorney , Advance decisions , court deputies and decisions of the court of protection. | Where these exist the care team is responsible to ensure they are recorded in the person's file.<br>Where there are concerns a deputy or attorney is not acting in line with the code of practice then the Office of The Public Guardian should be consulted and safeguarding policies followed.                   | For situations where they are applicable staff members need to ensure they are valid and if so follow them. For doubts about lasting powers of attorney the office of the public guardian can be contacted to verify its validity.  |
| Disputes and the Court of Protection   | When there is a dispute that cannot be resolved then consideration should be given to approaching the Court of Protection.   | Some situations are so serious an application to the Court of Protection should always be made. In other situations the processes outlined on p13 should be followed  |
| Ill treatment and wilful neglect of a person who lacks   | All staff must be aware of the offence.  | Safeguarding policies to be followed where there are concerns for vulnerable adults.  |
| Deprivation of Liberty Safeguards (DOLS).  | All staff must be aware of and follow this policy, the DOLS code of practice and Trust policies relating to restraint and care planning.<br>All staff must ensure any restrictions on a person who lacks capacity are as less restrictive as possible, in the person's best interest, necessary and proportionate. | In situations in which a person lacks capacity to consent to their care arrangements, are under continuous supervision and control and not free to leave then they are deprived of their liberty. This must be authorised. This will be by the Mental Health Act, DOLS procedures or the Courts depending on the situation. |

## TABLE OF CONTENTS

| Item     | Contents  | Page      |
|----------|---|-----------|
| <b>1</b> | <b>INTRODUCTION AND PURPOSE</b>                                       | <b>7</b>  |
|          | Summary of key issues   |           |
| <b>2</b> | <b>SCOPE AND DEFINITION</b>   | <b>9</b>  |
|          | Limitations of the Act with regard to Age                             |           |
| <b>3</b> | <b>PROCESS/REQUIREMENTS</b>   | <b>10</b> |
|          | Decisions that cannot be made under the Act                           | 10        |
|          | Assessing Capacity  | 10        |
|          | Best Interest   | 13        |
|          | Protection from Liability under section 5 of The Act and Restraint    | 18        |
|          | Section 5 and the Management of Money for those who Lack Capacity     | 19        |
|          | Advance decisions   | 19        |
|          | Lasting Power Attorney (LPA) and Enduring Power of Attorney (EPA)     | 20        |
|          | Independent Mental Capacity Advocate (IMCA)                           | 21        |
|          | Dealing with Disputes   | 22        |
|          | The Court of Protection   | 22        |
|          | Office of The Public Guardian   | 24        |
|          | Ill treatment and wilful neglect of a person who lacks capacity       | 24        |
|          | Deprivation of Liberty Safeguards (DOLS)                              | 24        |
|          | Reporting Risk events   | 31        |
| <b>4</b> | <b>ROLES AND RESPONSIBILITIES</b>                                     | <b>31</b> |
|          | Staff Responsibilities  | 31        |
|          | Internal documentation system   | 31        |
| <b>5</b> | <b>TRAINING</b>   | <b>31</b> |
| <b>6</b> | <b>EQUALITY &amp; DIVERSITY AND MENTAL CAPACITY ACT</b>               | <b>32</b> |
| <b>7</b> | <b>SUCCESS CRITERIA /MONITORING THE EFFECTIVENESS OF THE DOCUMENT</b> | <b>32</b> |
| <b>8</b> | <b>REVIEW</b>   | <b>32</b> |

|           |   |           |
|-----------|---|-----------|
| <b>9</b>  | <b>REFERENCES AND LINKS TO OTHER DOCUMENTS</b>              | <b>32</b> |
|           |   |           |
| <b>10</b> | <b><u>Appendixes</u></b>                                    |           |
|           | Appendix 1A Assessment of Capacity form                     | 34        |
|           | Appendix 1B Hospital admission and Capacity Form            | 36        |
|           | Appendix 2 Best Interests form                              | 37        |
|           | Appendix 3 Referring to an IMCA                             | 40        |
|           | Appendix 4 Guidance on establishing a best interest meeting | 41        |
|           | Appendix 5 DoLs poster                                      | 50        |
|           | Appendix 6 Auditing standard                                | 51        |
|           | Appendix 7 Equality and HR and MCA Impact Assessment        | 56        |

# The Deprivation of Liberty Safeguards and The Mental Capacity Act 2005 Policy

## 1. INTRODUCTION & PURPOSE

- 1.1 This policy sets the standards staff members are expected to follow in implementing the principles of the Mental Capacity Act 2005 and the guidance in the Act's Code of Practice. The policy is particularly relevant when staff members, including Associate Hospital Managers and Non- Executive Directors are working with service users who may lack capacity to make particular decisions at the time or in the future.
- 1.2 Nothing in the Mental Capacity Act, taken alone, gives staff member's powers to coerce, compel or control families in their care of their family members. The duty is to work in partnership to promote the autonomy, safety and best interest of those who lack capacity. In many situations the family members will be the decision makers and staff member's role will be to support them.
- 1.3 The policy aims to promote the dignity, capacity, choice and participation of service users who may lack capacity to make particular decisions at some point. It is expected that this is an approach taken throughout the planning and delivery of care. Specifically, all staff should consider how their intervention will impact upon the capacity and participation of the service user. In doing so, staff will be expected to appropriately encourage the participation of carers and family and give a thorough consideration of any safeguarding issues in line with the Trust's safeguarding policies.
- 1.4 The Mental Capacity Act 2005 (MCA) requires that organisations identify when people lack, or are thought to lack, mental capacity in making decisions in order that special measures can be employed to assist them. All Solent NHS Trust staff that come into contact with patients, their relatives and carers and the public must be aware of the requirements of the Act and their responsibilities under statute.
- 1.5 The Act defines five statutory principles. These are:
- A person must be assumed to have capacity unless it is established that they lack capacity.
  - A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
  - A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
  - An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
  - Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
- 1.6 These principles must be clearly demonstrated when people who lack capacity need to have decisions made on their behalf. All actions taken on behalf of those who lack capacity to make a particular decision must be consistent with them. This includes the process of assessing capacity. This policy supports these principles and clarifies how they will be reflected in practice.
- 1.7 This policy will:
- Summarise the purpose of the Act;
  - Define patient groups to whom this Act pertains;
  - Define the standard of assessment of mental capacity and best interests expected in Solent NHS Trust;
  - Describe how a capacity and best interests assessment are to be recorded;
  - Signpost to guidance on the management of finances for someone who lacks capacity;
  - Describe the effects of advance decisions, Lasting Powers of Attorney, Enduring Power of Attorney, and court appointed deputies on assessments of best interest;

- Describe the Role of Independent Mental Capacity Advocate (IMCAs) and define SOLENT NHS TRUST staff member's duty to refer;
- Set out the process for resolving disputes over capacity or best interest assessments and the role of the Court of Protection and The Office of The Public Guardian;
- Describe the new criminal offence of ill treatment or wilful neglect of a person who lacks capacity to make relevant decisions (section 44);
- Describe the Deprivation of Liberty Safeguards, and the responsibilities and duties of SOLENT NHS TRUST staff with regard to these.

## 2. SCOPE & DEFINITIONS

2.1 This document applies to all directly and indirectly employed staff members, including Associate Hospital Managers and Non- Executive Directors within Solent NHS Trust and other persons working within the organisation in line with Equal Opportunities Document. This document is also recommended to Independent Contractors as good practice.

2.2 This guideline applies to all Solent NHS Trust staff. This is based on the assumption that all staff will potentially come into contact with people who lack, or are thought to lack, capacity. It applies to any patient where there are concerns about their capacity, particularly with regard to an important decision (see definition below) whilst in the care of any Solent NHS Trust service.

2.3 People may lack capacity with regard to specific decisions.

The following people may lack capacity:

- People with a learning disability
- People with a cognitive impairment (e.g. with dementia)
- People with a brain injury
- People under the influence of drugs or alcohol
- People with a delirium (acute confused state)
- People with a mental health problem

This list is not exclusive and practitioners should always be alert to others who may lack capacity, whether temporarily or due to a more chronic underlying cause.

### 2.4 Limitations of the Act with regard to Age

2.4.1 Within the Code of Practice for the Act, "children" refers to people under the age of 16 and "young people" refers to people aged 16-17.

2.4.2 The Act does not apply to children under the age of 16, although there are two exceptions:

- The Court of Protection can make decisions or appoint a deputy to make decisions regarding a child's property or finances where the child lacks capacity to make related decisions and is likely to still lack capacity at 18.
- Offences of ill treatment or wilful neglect of a person who lacks capacity can apply to victims younger than 16.

2.4.3 Most of the Act applies to young people aged 16-17 years who lack capacity to make specific decisions. There are four exceptions:

- Only people aged 18 and over can make lasting powers of attorney
- Only people aged 18 and over can make an advance decision to refuse specific medical treatments
- The Court of Protection may only make a statutory will for people aged 18 and over
- The Deprivation of Liberty Safeguards only applies to people 18 years and over.

2.4.4 Where there are disagreements concerning care, treatment or welfare of a young person aged 16-17 who lacks capacity to make related decisions, the case may be heard in the Court of Protection or the family courts depending on circumstances. Cases can be transferred between the courts.

## 3. PROCESS/REQUIREMENTS

### 3.1 Decisions that cannot be made under the Act

Sections 27–29 and 62 of the Act set out the specific decisions which can never be made or actions or which can never be carried out under the Act, whether by family members, carers, professionals, attorneys or the Court of Protection. These are summarised below.

#### 3.1.1 Decisions concerning family relationships (section 27):

Nothing in the Act permits a decision to be made on someone else's behalf on any of the following matters:

- consenting to marriage or a civil partnership
- consenting to have sexual relations
- consenting to a decree of divorce on the basis of two years' separation
- consenting to the dissolution of a civil partnership
- consenting to a child being placed for adoption or the making of an adoption order
- discharging parental responsibility for a child in matters not relating to the child's property, or
- giving consent under the Human Fertilisation and Embryology Act 1990.

However, a person can still be assessed to lack capacity in relation to making specific decisions in relation to these issues. What cannot be done is to make a best interest decision in relation to these issues or for a deputy or attorney to consent on behalf of a person who lacks capacity in relation to one of these issues.

#### 3.1.2 Mental Health Act matters (section 28):

Where a person who lacks capacity to consent is currently detained and being treated under Part 4 of the Mental Health Act 1983, nothing in the Act authorises anyone to:

- give the person treatment for mental disorder, or
- consent to the person being given treatment for mental disorder.

#### 3.1.3 Voting rights (section 29):

Nothing in the Act permits a person to be prevented from voting on the grounds of a lack of capacity.

#### 3.1.4 Unlawful killing or assisting suicide (section 62):

For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

### 3.2 Assessing Capacity

#### 3.2.1

Chapter 4 of The Code of Practice gives extensive guidance on assessing capacity and should be read in conjunction with this policy. General practitioners may also find the Royal College of General Practitioners Mental Capacity Act (MCA) Toolkit for Adults in England and Wales 2011 helpful. It can be located here: <http://www.rcgp.org.uk/~media/Files/CIRC/CIRC-76-80/CIRC-Mental-Capacity-Act-Toolkit-2011.ashx>

#### 3.2.2

When assessing a person's capacity the five principles of the Act, stated above, must be followed. Particular regard should be given to a person's communication needs, and the impact of the people involved in the assessment, the time of day it is undertaken and the environment in which a person is assessed.

#### 3.2.3

A person's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it needs to be made.

#### 3.2.4

It must not be assumed that a person lacks capacity because they make an unwise decision.

#### 3.2.5

A person's capacity must not be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour. The Act sets out a 2 stage capacity test:

- Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

- Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

3.2.6 A person is unable to make a decision if they cannot:

- understand information about the decision to be made (the Act calls this 'relevant information')
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (by talking, using sign language or any other means). See section 3(1).

3.2.7 A person can only be said to lack capacity if a clear link or nexus is established between the impairment of their mind or brain and the inability to do 1 to 3 of the above. The exception to this is if a person lacks capacity because they are unable to communicate their decision. A person can also only be said to lack capacity for a particular decision if practicable steps cannot be taken to promote their capacity. This includes helping them to understand the decision. In this regard the assessor must first be clear what the decision is, what information the person needs to understand and how they are going to share this information with the person in a meaningful way. A person's understanding should only be assessed once the information they need to understand is shared with them. A capacity assessment is an intervention to promote capacity wherever possible and not a test to find pathology.

3.2.8 A person's level of understanding of the issues should reflect the significance of the decisions and the risks associated with it. Assessors will need to ensure they get the correct balance between not placing the bar too high and expecting a level of understanding that the average person would not have, whilst, at the same time guarding against superficiality in their assessment of the person's understanding. To this end it will be helpful if, before undertaking the assessment, they decide exactly what it is the person needs to understand.

3.2.9 For 'important decisions' (see below), which includes consent to care plans, the lead professional directing that aspect of the patient's care is responsible for assuring the capacity of the service user is assessed and recorded on the electronic system or on the form in appendix 1, by following the process chart. A person's capacity only needs to be assessed when there are concerns regarding their capacity to make the decision in question. Who assesses the capacity will be the person best placed to take on the role and will depend on what the decision is about. Normally this will be the lead professional directing that aspect of the patient's care. Although in some circumstances another member of staff will be better placed or have the necessary expertise. Only registered practitioners can undertake these assessments for important decisions. For complex medical or welfare decisions these will usually be taken in the context of a multi-disciplinary team. However, it is important to be clear who the lead professional directing the care is and who is responsible for assuring the capacity assessment is appropriately undertaken and recorded.

3.2.10 If a person who lacks capacity to consent is admitted to a Solent NHS Trust inpatient unit, in their best interest, the form in APPENDIX 1A, will be completed. Consideration must be given as to whether the patient is deprived of their liberty. A person's capacity to consent to aspects of their care, best interest decisions and consideration as to whether there is a deprivation of liberty or not must be kept under regular review.

3.2.11 Where Solent NHS Trust is not the lead agency for that particular component of the intervention they will not normally be the decision maker. The nominated person from the agency directing the intervention retains over all responsibility for the capacity assessment, even if assisted by a psychiatrist or psychologist.

### 3.2.12 **Vulnerable Adults and Capacity**

The capacity assessment is an assessment of a person's cognitive functioning in relation to a specific decision at a specific time. Being vulnerable, therefore, does not in itself mean that a person lacks capacity to make choices. If a person has capacity they are entitled to make unwise choices. However, where a person's vulnerability is in part due to difficulties they have with cognitive functioning it may

mean that they lack capacity with regard to an issue as well as being vulnerable. It may also be that a stressful situation affects their impairment and a person's capacity to make choices and means in these situations they lack capacity.

Furthermore, having capacity is only one component that makes a decision valid. The other is that it is freely made. Therefore undue influence can make a decision invalid. This includes the influence of professionals and non-professionals.

It is important for professionals to consider what steps they can take to promote a person's decision making capacity. This includes considering the effect of their and other's influence and a patient's social situation. This includes ensuring any safeguarding issues are appropriately addressed.

Even where a person has capacity to make decisions it may be that they can be empowered to make more autonomous decisions by helping them to develop self-esteem, be more assertive in relationships, have access to independent support and advice, and have their own access to resources. This is particularly important where vulnerable adults may be in abusive relationships.

However, it is always essential to determine whether a person has capacity by applying the statutory test to a specific issue at a specific time. If they have capacity for that decision then they have the right to choose. However, if a person lacks capacity in relation to the specific issue then the issue needs to be decided in their best interest.

### **3.2.13 Fluctuating Capacity**

Some people have fluctuating capacity – they have a problem or condition that gets worse occasionally and affects their ability to make decisions. Temporary factors may also affect someone's ability to make decisions.

In such cases, it is good practice to establish, while the person has capacity, their views about any clinical intervention that may be necessary during a period of anticipated incapacity, and to record these views. The person may wish to make an advance decision to refuse treatment or a statement of their preferences and wishes. It should also be considered whether the person is likely to regain capacity and, if so, whether the decision can wait. The statutory principle that all practical steps must be taken to enable the person to make their own decision should be followed. Each service should have a clear process that sets out where advance decisions to refuse treatment and advance statements of wishes and feelings are recorded.

### **3.2.14 Ongoing Conditions that may affect Capacity**

Generally, capacity assessments should be related to a specific decision. But there may be people with an ongoing condition that affects their ability to make certain decisions or that may affect other decisions in their life. One decision on its own may make sense, but may give cause for concern when considered alongside others. This concern may trigger a capacity assessment. However the assessor should be clear that the assessment is of the person's cognitive functioning at that time in relation to the decision being considered and not based solely on the decision the person makes: the process the person went through in reaching the decision is what is being assessed.

Where the underlying reason or condition why someone experiences an impairment of the mind or brain is of a long term nature, the nature of this and the impact of it on decision making should be thoroughly assessed. This should help inform what steps can be taken to promote capacity and highlight factors to be considered when assessing capacity in relation to a specific issue at a specific time.

It is important to review capacity from time to time, as people can improve their decision-making capabilities. In particular, someone with an ongoing condition may become able to make some, if not all, decisions. Some people (for example, people with learning disabilities) will learn new skills throughout their life, improving their capacity to make certain decisions.

Although there is no specific time limit on when to review capacity in relation to a decision, good practice would require reviewing capacity regularly. Capacity should always be reviewed:

- whenever a care plan is being developed or reviewed,
- if there is a significant change in clinical presentation,
- at other relevant stages of the care planning process (specific teams will need to decide on this for their area of work), and
- as particular decisions need to be made.

### 3.2.15 Important Decision

The MCA covers a wide range of decisions. It is not expected that a full assessment will need to be made and documented for each decision that a person might have to make whilst receiving care and treatment from Solent NHS Trust. This does not mean that the decision itself is any less important to that person. Rather, that for some decisions using the full recording process would be a disproportionate response. The more complex, contentious and/ or the greater the consequences are; the greater the assessment and the more thorough the recording needs to be. Major decisions that have the potential to affect a person's health or well-being, and those which are contentious should be recorded on the specific electronic system forms, or where an electronic system is not available on the forms in the appendix A and B. These decisions will be referred to as 'important decisions'. They include consent to care plans.

All decisions should have the process applied in principle. Decisions about low risk interventions such as providing personal care do not need to have this process recorded on the attached forms in every instance, unless there is evidence or indication that the patient may find the decision contentious. However, it is good practice that all staff should learn to make a mental assessment of capacity when it is in doubt and act accordingly with regard to helping the person make a decision, and considering their best interest. It is good practice for this to be briefly and simply recorded within the person's notes.

## 3.3 Best Interest

3.3.1 Chapter 5 of The Code of Practice should be consulted for further guidance on assessing what is in a person's best interest.

3.3.2 One of the key principles of the Act is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's *best interests*. That is the same whether the person making the decision or acting is a family carer, a paid care worker, an attorney, a court-appointed deputy, or a healthcare professional, and whether the decision is a minor issue; like what to wear, or a major issue; like whether to provide particular healthcare.

3.3.3 The Act does not give a specific definition for 'best interest' but rather, states a duty on those intervening without consent of the person because of a lack of capacity to follow a process in deciding what is best. This includes identifying all the relevant factors, seeking to encourage and ensure the person's participation and consulting relevant others. The starting point is seeking to understand the world from that person's point of view and the aim is to make a decision that is right for that individual person. Best Interest is wider than medical or clinical best interest.

### 3.3.4 Decision Maker

All Solent NHS Trust Staff should be aware that nothing in the Mental Capacity Act gives staff members, including Associate Hospital Managers and Non- Executive Directors the power to coerce, compel or control families in the context of the care of adults that lack capacity. The duty on staff is to work with families to provide advice, support and services in partnership with families in order to promote the welfare, autonomy and best interest of those who lack capacity. For many issues the family will be the decision makers and it is staff responsibility to support them. This includes working with families to address any concerns regarding a person's care. When working to resolve any disagreements or reach consensus all staff must be prepared to step back and reflect on the experience of patients and carers; their frustrations, hopes, fears and difficulties. In situations in which coercive powers are needed staff members, including Associate Hospital Managers and Non-Executive Directors are responsible for ensuring they have lawful authority for their Acts and should seek advice if in doubt.

The Mental Capacity Act does not itself use the term ‘decision maker’. However, it does set out a number of duties on those directing and carrying out interventions when the person lacks capacity to consent to it. The Code of Practice uses the term to identify who these duties apply to. In order to ensure these duties are discharged this policy defines the role of decision maker in Solent NHS Trust.

For ‘important decisions’ what is in a person’s best interest will be determined by the ‘decision maker’. The decision maker is the person best placed within the agency to undertake this role. Who this is will depend on the nature of the decision to be made. However, it will normally be the lead professional directing that aspect of the patient’s care unless there is a reason specific to the case why another professional should undertake the role. An example could be specific and relevant expertise needed due to the complexity of the patient’s medical needs.

As with capacity assessments, the more complex/ contentious or the greater the consequences the more thorough the assessment and recording needs to be. Important decisions should be decided in the context of a multi-disciplinary team but being clear who the decision maker is.

In order to ensure the duties to consider all the relevant factors and consult the appropriate people are discharged, some of these decisions may be best decided by a best interest meeting or series of meetings. In determining if the threshold for such a meeting is reached the following factors should be considered:

- the complexity of the decision,
- the nature and degree of risk associated with the outcomes,
- safeguarding issues
- disagreement between professionals or professionals and family over what is in the person’s best interest
- risk of the person being deprived of their liberty

In deciding if the threshold is reached the cumulative effect of these factors needs to be considered. However, serious concerns in one of the areas may be enough to trigger the need for the meeting. Appendix 5 gives guidance on undertaking best interest meetings, and sets out a template for minutes. The Mental Capacity Act intranet site contains leaflets to give to patients, carers and professionals on the Act and best interest decisions.

The processes for considering and recording best interest decisions can be summarised in the table below.

| Decision level   | Who should be involved  | How decision is recorded  |
|--|---|---|
| Simple decision  | Staff member carrying out the Intervention.<br>The service user and family should be consulted as much as is possible.<br>Staff should be trained in the best interest decision making process and this should inform their practice. | As part of recording the intervention in the person’s notes   |
| Hospital admission to a Solent NHS Trust inpatient unit for a person who lacks capacity to consent | The admitting professional should complete the assessments. These should be reviewed regularly.   | If a person who lacks capacity to consent is admitted to a Solent NHS Trust inpatient unit, in their best interest, the form in APPENDIX 1A will be completed |

|  |   |  |
|--|---|--|
| A Multi-Disciplinary Team (MDT) care plan. | The MDT team should involve the person and relevant others.   | On the best interest decision making form on the electronic system, where an electronic system is not available the form in the appendix should be used.   |
| 'important decision'                       | Clinician directing the intervention (decision maker). The Multi-disciplinary team should be consulted<br>The person and informal carers and families views should be established and it decided what weight to give them.<br>The best interest decision making process should be followed and clearly recorded.<br>IMCA referral should be made where the criteria is met.             | On the best interest decision making form on the electronic system, where an electronic system is not available the form in the appendix should be used.   |
| Best interest meetings                     | Clinician directing the intervention (decision maker). Appropriately senior manager Representatives from the agencies/ teams involved.<br>A process for involving and considering the patient and families views should be identified.<br>The best interest decision making process should be followed and clearly recorded.<br>IMCA referral should be made where the criteria is met. | Minutes of the meeting should record the decision making process. These should be made available to the patient and family in an appropriate format. These should be recorded or referenced in the best interest component of the electronic records system. |

No matter how a patient's capacity is assessed and what is determined as being in their best interest all staff have a vital role to play in delivering care and carrying out interventions. Those involved in carrying out the care plans retain responsibility to consider how they can do so in the best interests of the person and to raise concerns if they believe the person has regained capacity or if the intervention is no longer in the person's best interest.

### 3.3.5 Process for Determining Best Interest

The Act and Code of Practice set out what process a decision maker should follow in establishing a person's best interest. This is the best interest checklist:

- Consider if the person will regain capacity and if the decision can wait.
- As far as is reasonably practicable permit and encourage participation of the person or improve his ability to participate as fully as possible.
- As far as is reasonably ascertainable consider:
  - the person's past and present wishes and feelings and any written statements about the issue, they made when they were able to;
  - the beliefs and values that would be likely to influence the person if they were able to make the decision; and
  - the other factors that the person would see as important.
- Avoid discrimination:
  - Do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.
- Life sustaining treatment
  - if the decision concerns life-sustaining treatment the decision must not be motivated in any way by a desire to bring about the person's death. They should not make assumptions about the person's quality of life.
- Consult and take into account as far as is practicable and appropriate:
  - anyone the person said should be consulted about this type of issue;
  - anyone caring for or concerned about the person;
  - anyone of a power of attorney granted by the person;
  - any deputy appointed for the person by the Court.
- Avoid restricting the person's rights: explore less restrictive options were possible.
- Take all of the above into account when making a decision.

The starting point should always be to seek to see the world through the person's eyes and take a holistic approach to the decision. However, those making decisions are not bound by the wishes and feelings of the person.

Each situation is different and what the relevant factors are will need to be decided on the facts of that situation. Likewise, the facts will need to be considered when deciding what weight is given to each factor. Best practice is to take a score card approach: identifying the relevant factors and possible choices, then recording the positives and negatives of each, the likelihood of the positive or negatives occurring, deciding what weight to give them and reaching a conclusion.

It is essential that when considering the pros and cons of particular alternatives appropriate considerations are given to the impact they are likely to have on the person's enjoyment and meaning in life, particularly with regard to their experience of a private and family life. This includes both the person's relationship with their family and their autonomy and developmental needs. The importance of each needs to be teased out in the circumstances of each case; in some cases family relationships will be more important and others developmental needs and independence. In some cases they will be compatible and in others some conflict will be involved.

Likewise, when considering issues such as happiness, safety, autonomy and social belonging it will often be the case that no easy solution will be reached and not all of these will be met. This is particularly true as many interventions will be at times of crisis, illness or vulnerability. Practitioners should be careful not to introduce hard and fast rules about which of these is more important. The importance of each case needs to be decided in the circumstances of each case, remembering that each case is different. Decisions can always be kept under review and reconsidered in the light of changes or new information.

As stated below, when considering these issues the starting point is the best interest of the person concerned and their wishes and feelings. This principle applies to both professionals and family members making decisions on behalf of those who lack capacity and the onus should be on working together to meet the best interest and resolve disputes. If disputes cannot be resolved then the court of protection may be needed to decide.

### 3.3.6 **Patient's Current Wishes and Feelings**

It is always important to determine the patient's wishes and feelings and to give them proper consideration when deciding on a patient's best interest.

The starting point should always be trying to understand the world through the person's eyes. However, in some cases they may not be determinative. What weight to give them will depend on the facts of each case. In deciding this the following should be taken into account:

- the degree of the person's incapacity, for the more of the situation and consequences they understand the more weight must in principle be attached to their wishes and feelings
- the strength and consistency of the views being expressed by them
- the likely impact on them of the knowledge that their wishes and feelings are not being followed.
- the extent to which their wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and
- crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the overall assessment of what is in her best interests.

### 3.3.7 **Statements of Wishes and Feelings**

Whilst a person has capacity they may have written a statement of wishes and feelings. In some cases they may have done this with family or professionals. This is an important way of them communicating what they want to happen if they lose capacity and should be encouraged. In mental health services this can be done through advance directives and forms part of the Care Program Approach process. These statements should always be taken into account when deciding best interest and incorporated as much as possible into the best interest plan. However they are not always determinative in deciding best interest and there may be justifiable reasons why they are not followed. If this is the case then reasons for this should be clearly recorded. Care, and where appropriate advice, should be taken to ensure they are valid reasons.

The issue of covert medication is covered in the Trusts Medicines policy. For medication given covertly under the Mental Health Act 1983 there is separate guidance in that policy. For medication that is not given under the Mental Health Act in situations in which the person lacks capacity and a decision needs to be made regarding covert administration then the best interest form should be completed. The assessment must include:

- the patient's understanding in relation to the treatment
- if the patient is likely to regain capacity
- if attempts should be made from time to time to administer non-covertly and if not, why not
- the risk of the patient not receiving treatment if covert medication is not tried and the risks this has for the patient
- consideration of why the assumption in favour of disclosure is not being followed
- consideration of why the patient's wishes and views are not being followed
- the pharmaceutical consequences of covert administration
- if it is medication for a mental disorder why the Mental Health Act 1983 is not being used to authorise it, and
- how arrangements will be reviewed (these must be at least one month, three months, six months and then annually)
- If the person is deprived of their liberty and how this should be authorised

### 3.3.8 **Resource Considerations**

A person without capacity has the same right as others to resources and services. Before considering what is in a person's best interest the options that are actually possible need to be identified. This may mean approaching the relevant local authority or primary care trust. Only after establishing what is actually possible can what is in a person's best interest be determined from those options.

### 3.3.9 **Situations where the Best Interest Process is not followed**

There are two circumstances when the best interest principle will not apply:

- The first is where someone has previously made an advance decision to refuse medical treatment while they had the capacity to do so. Their advance decision should be respected when they lack capacity, even if others think that the decision to refuse treatment is not in their best interests.
- The second concerns the involvement in research of someone lacking capacity to consent, but only in certain circumstances. The Trust has a separate policy on research. It covers this area and it should be consulted for further information. This area is also covered in chapter 11 of The Code of Practice.

## 3.4 **Protection from Liability under section 5 of The Act and Restraint**

- 3.4.1 The Mental Capacity Act does not give any specific powers for those intervening on behalf of a person that lacks capacity to consent but rather sets out a number of duties that must be met in these circumstances. Providing these duties are met those undertaking these interventions will be given protection from liability.
- 3.4.2 Section 5 of the Act gives protection from liability to the decision-maker or carer acting in the best interests of someone when they lack capacity to make decisions for themselves, or to consent to acts concerned with their care or treatment. When restraint is needed to ensure a person who lacks capacity to receive medical treatment then there are additional duties that must be met. These are defined in section 6 of the Act.
- 3.4.3 The MCA has a very wide definition of restraint and this needs to be kept in mind when determining best interest. Section 6(4) of the Act states that someone is using restraint if they use force, or threaten to use force to make someone do something that they are resisting or restrict a person's freedom of movement, whether they are resisting or not.
- 3.4.4 Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the person taking action reasonably believes that restraint is necessary to prevent harm to the person who lacks capacity, and the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.
- 3.4.5 The harm could occur because the person will harm themselves if the act is not done or, they will be harmed by a need not being met. Likewise, the restraint may be an essential element of preventing the harm or an unintended consequence of meeting other needs. For example shutting a door so someone cannot wander into the street would be an essential element of preventing the harm. Whereas, the side effects of a particular medication, for example sedation, or the limitations in the routine of a particular home, would be unintended restrictive consequences of seeking to meet the person's needs. However, the restrictions could have just as significant an impact on that person and could contribute to restrictions amounting to a deprivation of liberty. In deciding whether the action is still in the person's best interest, the restrictions should be weighed in the balance against the benefits of the intervention, possible less restrictive alternatives and harms of not intervening. They should only proceed if it is the less restrictive alternative and the restrictions caused are proportionate to the need to prevent the likely harms that could occur by not acting and the benefits of acting.
- 3.4.6 In particular, section 5 does not offer protection from liability when restraint amounts to a deprivation of liberty unless this is legally authorised.

- 3.4.7 If restraint is needed for an inpatient in a psychiatric hospital then the care team should consider if the person is objecting to being in hospital or receiving the treatment for his mental disorder. If there is reason to think that a patient would object, if able to do so, then the patient should be taken to be objecting. If it is decided the patient is objecting due thought should be given to using the provisions set out under The Mental Health Act 1983 and the reasons and decision recorded.
- 3.4.8 All staff within clinical areas should be familiar with the Trust procedures and guidance of their area with regard to restraint.

Where a care plan for a person who lacks capacity involves any form of restraint this must be regularly reviewed to ensure it is the least restrictive involvement and, given the above considerations, remains appropriate and there is appropriate authorisation for any deprivation of liberty.

### **3.5 Section 5 and the Management of Money for those who Lack Capacity**

- 3.5.1 The Code of Practice 6.56 to 6.66 gives guidance on the management of finances for someone who lacks capacity. A carer (paid or unpaid) can use a person's money to pay for goods providing that they are necessary, in the person's best interests and comply with the conditions of section 5. These actions will need to be carefully considered and when involving Trust staff should be recorded in the care plan and clear documentation kept, including receipts. No action should conflict with:
- a Lasting Power of Attorney (LPA),
  - Enduring Power of Attorney (EPA),
  - advance decision,
  - a decision of the court of protection or deputy appointed by the Court of Protection.
- 3.5.2 Consideration should also be given, taking into account any safeguarding concerns, as to whether it is more appropriate for an informal carer to take on this role.
- 3.5.3 Each team will need to agree their procedures and guidelines in relation to this power.
- 3.5.4 Section 5 does not give authority to access a person's income or assets or sell their property. More formal powers are needed for these actions. These include, LPA, EPA, a court appointed deputy or in the case of the management of benefits, appointeeship (under Social Security regulations). In some cases an application to the Court of Protection may need to be made. These issues are dealt with in the relevant sections below. For further guidance the Client Affairs Team at Portsmouth City Council should be contacted on 023 92688199. The pathway for referrals into the Client Affairs Team is in APPENDIX 7 and should be followed by teams within Solent NHS Trust that are integrated with the Portsmouth City Council.
- 3.5.5 For patients residing in Southampton the adult social care team should be contacted on 02380 833003.

### **3.6 Advance Decisions**

- 3.6.1 Chapter 9 of the Mental Capacity Act Code of Practice should be consulted for further guidance on advance decisions as should the Trust policy CLN/03 Advance Decisions to refuse treatment. Practitioners should note that if an advance decision is about life sustaining treatment it must be written and recorded in a specific format.
- 3.6.2 Health professionals should not become involved in the drafting of any Advance Decision for a patient, unless they have received specialist training on the issue. If asked, medical personnel should ask patients to obtain independent help with their Advance Decision. However, where a patient makes a verbal advance decision this should be recorded in patient's notes, witnessed, signed and dated. Solent NHS Trust staff can support people in making advance decisions by following the guidelines in CLN/03 Advance Decisions to Refuse Treatment.

### 3.7 Lasting Power Attorney (LPA) and Enduring Power of Attorney (EPA)

- 3.7.1 Chapter 7 of the Code of Practice should be consulted for further guidance on LPAs and EPAs.
- 3.7.2 The Mental Capacity Act replaced EPAs with LPAs. If a staff member has any concerns about the validity of an LPA or EPA they should request The Office of The Public Guardian to search their registers.
- 3.7.3 Enduring Powers of Attorney (EPA) allow the attorney to make certain decisions on behalf of the person who made the EPA. Some of their features are:
- No further EPAs can be made.
  - Existing EPAs are still valid.
  - EPAs only cover property and affairs.
  - EPAs can be used while the donor still has capacity to manage their own property and affairs.
  - EPAs must be registered with the Public Guardian when the donor can no longer manage their own affairs (or when they start to lose capacity).
- 3.7.4 A Lasting Power of Attorneys (LPAs) enables a person to nominate someone to make decisions on their behalf when they are no longer able to. Under an LPA, the chosen person (the attorney) can make decisions that are as valid as one made by the person (the donor).
- 3.7.5 LPAs can be registered at any time before they are used – before or after the donor lacks capacity to make particular decisions that the LPA covers. If the LPA is not registered, it can't be used.
- 3.7.6 There are two types of LPAs:
- Welfare LPA: covering health and personal welfare. This is only effective if the person lacks capacity with regard to the specific issue, and the LPA is registered.
  - Property and Affairs LPA: covering financial issues. These can be used before the donor lacks capacity unless the donor states not in the LPA.
- 3.7.7 The Code of Practice gives guidance on how to create, define the limits of an attorney's power and register LPAs.
- 3.7.8 Attorneys must follow the principles of the Act and act in the best interests of the donor. Where there are concerns that this is not being done the office of the public guardian should be consulted.
- 3.7.9 Where there is a valid welfare LPA covering the specific issue in question, except for the situations described below, the attorney becomes the decision maker. If there is a dispute then the guidance below should be followed.
- 3.7.10 Even where the LPA includes healthcare decisions, attorneys do not have the right to consent to or refuse treatment in situations where:
- **The donor has capacity to make the particular healthcare decision (section 11(7) (a))** An attorney has no decision-making power if the donor can make their own treatment decisions.
  - **The donor has made an advance decision to refuse the proposed treatment (section 11(7) (b))** An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment. But if the donor made an LPA after the advance decision, and gave the attorney the right to consent to or refuse the treatment, the attorney can choose not to follow the advance decision.
  - **A decision relates to life-sustaining treatment (section 11(7) (c))** An attorney has no power to consent to or refuse life-sustaining treatment, unless the LPA document expressly authorises this. In this situation, the attorney must not be motivated in any way by the desire to bring about the donor's death.

- **The donor is detained under the Mental Health Act (section 28)** An attorney cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act 1983

3.7.11 Details of Lasting Powers of Attorney should be recorded in the case notes including contact details for the attorney, the type of LPA made (property and affairs or welfare) and the type of decision the attorney has power to make.

### **3.8 Independent Mental Capacity Advocate (IMCA)**

3.8.1 Chapter 10 of the Code of Practice gives further guidance on IMCAs.

3.8.2 An IMCA is an independent person appointed to assist with decision making for those who lack capacity. The Trust has a duty to refer for an IMCA in certain situations. These are when a person is 'unfriended' and when any of the following are being considered:

- serious medical treatment
- NHS organised changes of residence lasting over 28 days

3.8.3 An IMCA *may* also be instructed to support someone who lacks capacity to make decisions concerning:

- care reviews, where no-one else is available to be consulted;
- adult protection cases, whether or not family, friends or others are involved.

3.8.4 'Unbefriended' means when there is no other suitable, non-professional person to represent them. If the care team is unclear if a person is unbefriended then this should be discussed with the IMCA service.

3.8.5 The IMCA's role is to support and represent the person who lacks capacity. Because of this, IMCAs have the right to see relevant healthcare and social care records. It is the responsibility of the consultant in charge of the care to decide what is relevant. The IMCA should be informed if they are being shown third party information that the service user is unaware of. The Confidentiality form should be completed (APPENDIX 3) and placed in the patient's notes.

3.8.6 Any information or reports provided by an IMCA must be taken into account as part of the process of working out whether a proposed decision is in the person's best interests. However, the decision maker is not under an obligation to follow it. See below for situations where there is a dispute.

3.8.7 The decision maker should refer to the IMCA service as soon as the service user's eligibility is identified. This will prevent any delay in treatment and care planning. The only situation in which the duty to instruct an IMCA need not be followed, is when an urgent decision is needed (for example, to save the person's life). This decision must be recorded with the reason for the non-referral. The care team will still need to instruct an IMCA for any serious treatment that follows the emergency treatment.

3.8.8 For Portsmouth this is done by the process in Appendix 3. The Southampton IMCA service operates during 9am – 5pm Monday to Friday. The service does not operate at weekends or on Bank or Public holidays. It provides an advocacy service for any person meeting the criteria who is accommodated or placed within the Southampton City Council boundary at the time the serious decision is requested to be made.

3.8.9 Referrals can be made to the IMCA service by emailing the electronic referral form available via the IMCA website. Referrals may be made by telephone to the IMCA service on 023 80637722.

### **3.9 Dealing with Disputes**

3.9.1 Chapter 15 of The Code of Practice gives further guidance on resolving disputes. Disagreements can occur regarding the assessment of a person's capacity to make a specific decision, as well as what is in a

person's best interest. The disputes may be between professionals, between families and/ or informal carers, between professionals and the family and/or informal carers, or between any of these and the person concerned.

- 3.9.2 Those involved in the disagreement may be carrying out their role as an IMCA, attorney or court appointed deputy.
- 3.9.3 Initially efforts should be made to resolve disagreements through discussion and meetings.
- 3.9.4 When disagreements are between professionals and family members then the following should be considered:
- setting out the different options in a way those involved can understand
  - inviting a colleague to talk to the family and offer a second opinion
  - offering to get independent expert advice
  - using an advocate to support and represent the person who lacks capacity
  - arranging a case conference or meeting to discuss matters in detail
  - listening to, acknowledging and addressing worries, and
  - where the situation is not urgent, allowing the family time to think it over.
- 3.9.5 If the dispute is still not resolved then further options to consider are:
- Involving a mediation service.
  - Family members, or the person themselves, can consider the Trust's complaints procedure.
  - The Health Service Ombudsman can be asked to investigate some problems that have not been resolved through formal complaints procedures.
- 3.9.6 Professionals need to be aware that nothing in the Act gives them the power to coerce, control or impose the will of the organisation on family caring for those who lack capacity. If agreement cannot be reached on significant issues then further advice should be sought as to whether to consider approaching the Court of Protection to determine the person's best interest. This is particularly important when considering issues such as residence and significant healthcare interventions.
- 3.9.7 When disputes are between professionals then due regard should be given to each professional's views. However, for medical interventions the final decision is made by the nominated decision maker. They may wish to seek further advice about proceeding or approaching the Court of Protection to make the decision.
- 3.9.8 When the decision maker, after discussion, disagrees with the IMCA then both views should be recorded and the decision maker should record why they disagreed and why they chose the different course of action.
- 3.9.9 In some cases some level of disagreement between professionals will have to be accepted, regardless of who the disagreement is between. The decision maker will choose the course of action unless something particular to the case makes it necessary to make an application to 'The Court of Protection' (see below).
- 3.9.10 Disputes about the finances of a person who lacks capacity should usually be referred to the Office of the Public Guardian (OPG) (see below) and may need an application to The Court of Protection.

### **3.10 The Court of Protection**

- 3.10.1 Chapter 8 of the Code of Practice gives further guidance on The Court of Protection.
- 3.10.2 Section 45 of the Act sets up a specialist court, the Court of Protection, to deal with decision-making for adults (and children in a few cases) who may lack capacity to make specific decisions for themselves.
- 3.10.3 The Court of Protection has the same powers, rights, privileges and authority as the High Court. When reaching any decision, the court must apply all the statutory principles set out in section 1 of the Act. In

particular, it must make a decision in the best interests of the person who lacks capacity to make the specific decision. There will usually be a fee for applications to the court.

#### 3.10.4 The Court of Protection has powers to:

- decide whether a person has capacity to make a particular decision for themselves
- make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions
- appoint deputies to make decisions for people lacking capacity to make those decisions.
- decide whether an LPA or EPA is valid, and remove deputies or attorneys who fail to carry out their duties.

#### 3.10.5 **When to make an application to the Court of Protection**

In the context of decisions about serious treatment there are some decisions that are so serious they should always be brought before the Court. These are:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- cases involving organ or bone marrow donation by a person who lacks capacity to consent
- cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
- all other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests. The significance of the decision, the other attempts to resolve disagreements made, and the risks and consequences attached to the decision will need to be considered in deciding if it is appropriate to make an application to the Court of Protection.

#### 3.10.6 Other cases where it is likely to be appropriate to make an application to the Court of Protection are:

- The court has guidance on when certain termination of pregnancy cases should be brought before the court.
- Cases involving ethical dilemmas in untested areas, or where there are otherwise irresolvable conflicts between healthcare staff, or between staff and family members.
- Cases where it is unclear whether proposed serious and/or invasive medical treatment is likely to be in the best interests of the person who lacks capacity to consent.
- An order of the court will usually be necessary for matters relating to the property and affairs (including financial matters) of people who lack capacity to make specific financial decisions for themselves, unless their only income is state benefits, or they have previously made an Enduring Power of Attorney (EPA) or a Lasting Power of Attorney (LPA) to give somebody authority to manage their property and affairs
- Circumstances in which there is an unauthorised deprivation of liberty and the DoLs procedures or the Mental Health Act are not available to authorise it. This is likely to be the Court of Protection but in some cases may be the high court.

3.10.7 The Court of Protection can also appoint a deputy to make particular decisions. This may be appropriate where ongoing decisions need to be made. However, where possible, the court should make the decision itself and if a deputy needs to be appointed, their appointment should be as limited in scope and for as short a time as possible. Chapter 8 of the Code of Practice gives further guidance on court appointed deputies.

3.10.8 When it is considered that an application to the Court of Protection is likely to be needed the Multi-Disciplinary Care Team should consult with the Mental Capacity Act Lead, at the earliest opportunity to enable specialist legal advice to be sought.

3.10.9 Practice directions and rules for the Court of protection can be downloaded from the Court of Protection website. Further information on the Court of Protection, including rulings, statutory forms and service standards can be accessed via the Office of The Public Guardian, <http://www.publicguardian.gov.uk/index.htm>.

### 3.11 Office of The Public Guardian

- 3.11.1 Section 57 of the Act creates a Public Guardian, supported by staff of the Office of the Public Guardian (OPG). The Public Guardian helps protect people who lack capacity by:
- setting up and managing a register of LPAs
  - setting up and managing a register of EPAs
  - setting up and managing a register of court orders that appoint deputies
  - supervising deputies, working with other relevant organisations (for example, social services, if the person who lacks capacity is receiving social care)
  - sending Court of Protection Visitors to visit people who may lack capacity to make particular decisions and those who have formal powers to act on their behalf (see paragraphs 14.10–14.11 below)
  - receiving reports from attorneys acting under LPAs and from deputies
  - providing reports to the Court of Protection, as requested, and
  - dealing with representations (including complaints) about the way in which attorneys or deputies carry out their duties.
- 3.11.2 The Office of the Public Guardian website gives further details of its role, LPAs, EPA, guidance for deputies and processes for a requesting a search of its register.

### **3.12 Ill treatment and Wilful Neglect of a Person who lacks Capacity**

- 3.12.1 The Act introduces two new criminal offences: ill treatment and wilful neglect of a person who lacks capacity to make relevant decisions (section 44). The offences may apply to:
- anyone caring for a person who lacks capacity – this includes family carers, healthcare and social care staff in hospital or care homes and those providing care in a person’s home
  - an attorney appointed under an LPA or an EPA, or
  - a deputy appointed for the person by the court.
- 3.12.2 Any professional with safeguarding concerns for a person who lacks capacity should follow the organisation’s safeguarding policy.

### **3.13 Deprivation of Liberty Safeguards (DOLS)**

- 3.13.1 If a person who lacks capacity to consent is admitted to a Solent NHS Trust inpatient unit, in their best interest, the form in APPENDIX 1A, or an equivalent should be completed.
- 3.13.2 If there is any concern that an inpatient may be deprived of their liberty, the Mental Health Act does not apply and DOLS does apply then an urgent authorisation must be given and a standard authorisation requested. The procedure for this is detailed below.
- 3.13.3 The advice in this policy is correct at the time it was approved. However, case law may change, particularly with regard to what amounts to a Deprivation of Liberty. It is important for staff to seek further advice from the Mental Capacity Act and Health Act Lead if there is any doubt.
- 3.13.4 The Deprivation of Liberty Safeguards are dealt with in their own Code of Practice which is a supplement to the main Mental Capacity Act 2005 Code of Practice. This should be consulted for further guidance.
- 3.13.5 The DOL safeguards were introduced to prevent breaches of the European Convention on Human Rights (ECHR) such as the one identified by the judgment of the European Court of Human Rights (ECtHR) in the case of *HL v the United Kingdom* (commonly referred to as the ‘Bournewood’ judgment).
- 3.13.6 In this case a man with autism was admitted to a hospital. He lacked capacity to decide if he should be admitted or not. He was admitted under common law. His carers challenged his admission. The European

Court of Human Rights ruled that considering all the restrictions he was under and the circumstances surrounding his admission he was deprivation of liberty and that;

- it had not been in accordance with ‘a procedure prescribed by law’ and was, therefore, in breach of Article 5(1) of the ECHR, and
- there had been a contravention of Article 5(4) of the ECHR because HL had no means of applying quickly to a court to see if the deprivation of liberty was lawful.

3.13.7 The Mental Capacity Act 2005 has been amended to prevent further similar breaches of the ECHR, where it is not possible to use the provisions of The Mental Health Act 1983.

3.13.8 In summary the DOLS procedures are intended to be safeguards for those who lack capacity to consent to admission in hospital or residence in a care home. They are intended to ensure that when restrictions on a person amount to a deprivation of liberty then they only continue if necessary and if certain conditions are met.

3.13.9 The DOLS procedures must be followed for service users:

- who lack capacity specifically to consent to treatment or care in either a hospital or a care home; and
- the care can only be provided in circumstances that amount to a deprivation of liberty; and
- the care is in their Best Interest; and
- detention under the Mental Health Act 1983 is not appropriate for the person at that time.

3.13.10

If these requirements are met and there is any concern a person may be deprived of their liberty then a DOLS application must be pursued.

3.13.11 These safeguards are referred to in this Code of Practice as ‘deprivation of liberty safeguards’.

3.13.12 The safeguards should not be viewed as a punitive or negative measure. Their aim is wherever possible to prevent a deprivation of liberty occurring. However, in some cases the duty to safeguard a person, without capacity to decide on relevant matters in their care plan, will mean that the circumstances of their care amount to an unavoidable deprivation of their liberty in their best interests. In these cases the DOLS ensure that this is for no longer than necessary, is as less restrictive as possible and provide significant safeguards for the person. They also provide clear guidelines and legal protection for those involved, including professionals and family.

3.13.13 As stated above, DOLS only apply to people in a hospital or care home; they do not apply to people in private residence; and they only apply to people over 18.

3.13.14 An authorisation under DOLS can only be made if it is:

- in the person’s best interests to protect them from harm
- a proportionate response to the likelihood and seriousness of the harm, and
- there is no less restrictive alternative.

3.13.15 DOLS **cannot** be used when:

- the patient has made a valid and applicable advance decision refusing a necessary element of the treatment for which they are to be admitted to hospital
- the use of the safeguards would conflict with a decision of the person’s attorney or deputy or of the Court of Protection; or
- the patient lacks capacity to make decisions on some elements of the care and treatment they need, but has capacity to decide about a vital element and either has already refused it or is likely to do so.
- the DOLS cannot be used where the provisions of The Mental Health Act 1983 would take primacy.

3.13.16 The DOLS procedures were introduced as safeguards for those who lack capacity and are deprived of their liberty. It is not appropriate to use them to enforce the will of a particular organisation over that of a family. In such cases, where agreement cannot be reached advice should be sought about bringing the

matter before the Court of Protection to decide the issue. Similarly, when disputes about a person's residence cannot be resolved then it is likely to be inappropriate to rely on DOLS alone and consideration should be given to an application to the Court of Protection. Furthermore, a correct understanding of the 'best interest' process should lead to a full consideration of the importance of the person who lacks capacity's experience of a private and home life.

3.13.17 Likewise, it is not appropriate to use the safeguards to enforce a care plan that can be achieved in a less restrictive way that meets the needs of the person and addresses the risks. To this end, all restrictions and restraints should be kept under review to ensure they are necessary, proportionate and regard is had to less restrictive options.

3.13.18 It is important to bear in mind that, while the deprivation of liberty might be for the purpose of giving a person treatment, a deprivation of liberty authorisation does not itself authorise treatment. Treatment that is proposed following authorisation of deprivation of liberty may only be given with the person's consent (if they have capacity to make the decision) or in accordance with the wider provisions of the Mental Capacity Act 2005. If a person is deprived of their liberty for the purpose of receiving treatment or assessment for a mental disorder, as defined by the Mental Health Act 1983, and they object then the Mental Health Act must be used. If the person lacks capacity to consent to the admission, is deprived of their liberty, is admitted for the treatment of mental disorder but does not object then a choice needs to be made between the Mental Health Act and the DOLS procedures. This will be about which is most appropriate and least restrictive in the individual circumstances of the case.

### 3.13.19 What is 'Deprivation of Liberty'?

When considering this staff do not have to be certain that the threshold of deprivation of liberty is met before pursuing an application. If there is any concern that there may be a deprivation of liberty then an application must be pursued.

The test if someone is deprived of their liberty is whether that person is: under continuous supervision and control and is not free to leave. If they meet this objective test and have not consented to the arrangements then they are deprived of their liberty.

When a person lacks capacity to consent to an admission it is the responsibility of the ward staff to identify any restrictions that are relevant to determining a deprivation of liberty. These issues should be considered by the multi-disciplinary team and it should be clearly recorded why this does or does not require the DOLS procedure to be followed or the Mental Health Act, if it applies. In particular, the significance of the particular liberties and restrictions considered should be recorded. These considerations should be kept under regular review.

In addition, at every stage of care planning professionals should be mindful of issues of capacity, promoting participation and reducing the level of any restriction to only what is necessary, proportionate and for a short a time as possible. This is particularly important within the context of a potential deprivation of liberty. This is a standard expected of all staff, in both their own practice, and clinical management of others, relevant to their level and should be an approach consistent throughout care planning and providing care. A deprivation of liberty could be prevented by ensuring;

- The Trust's care planning and recording procedures are followed, including regular reviews.
- The Trust's process and paperwork for assessing capacity and deciding on best interests are followed.
- The Trust's procedures on the use of observation and restraint are correctly followed.
- Serious consideration is given to promoting the participation of the service user and their significant others and contact between these is promoted.
- Advocacy services are fully and appropriately used.
- Autonomy on the ward and access to different areas is increased.
- Time off the ward is increased,
- Meaningful activities are increased.

### 3.13.20 When to apply The DOLS procedures when considering a move to a care home or admission to hospital

The procedures are in place as a safeguard against arbitrary detention in hospital or a care home they are not meant as a means for an NHS body or local authority to enforce a move to a care home or admission to hospital. In order to fully operate as a safeguard then wherever possible a request for a standard authorisation should be made before any move or admission in situations in which it is likely the person will be deprived of their liberty. This will ensure that the issues are properly considered and the procedure prescribed by law, namely the DOLS procedures, are applied before a person is deprived of their liberty and assurance can be given that Article 5 of the ECHR is complied with. See Chapter 6 of the Code of practice.

### 3.13.21 **The Mental Health Act and DOLS for Patients in Hospital**

Appendix 6 has a step by step process to follow where there are concerns a person without capacity may be deprived of their liberty.

There is guidance in the Code of Practice to The Mental Health Act 1983 and The Deprivation of Liberty Code of Practice on when to use the Mental Health Act 1983 and when to use DOLS. This should be read in the light of relevant case law.

In summary, when a person without capacity is in or is likely to be admitted to a hospital, receiving treatment/ assessment for a mental disorder, as defined within The Mental Health Act 1983, and;

- has or is likely to have their liberty deprived for that purpose or in the process of admission; or
- has an advance decision refusing treatment for the mental disorder or hospital admission; or
- objects or is likely to object to that treatment/ assessment; or
- objects to remaining in the hospital or being admitted to the hospital; or
- the patient's lack of capacity to consent is fluctuating or temporary and the patient is not expected to consent when they regain capacity. This may be particularly relevant to patients having acute psychotic, manic or depressive episodes

then a referral should be made for an assessment under the Mental Health Act 1983.

When restraint is used for a person lacking capacity who is already in a hospital for treatment/ assessment for a mental disorder then the following guidance in the Mental Health Act 1983 Code of Practice should be taken into account:

If a patient is not detained, but restraint in any form has been deemed necessary (whether as an emergency or as part of the patient's treatment plan), consideration should be given to whether formal detention under the Act is appropriate (subject to the criteria being met).

In considering the above professionals should clarify the purposes of all the treatment and assessment and what elements of it are for the mental disorder, as defined within the Mental Health Act 1983, and what parts of it are just for the physical disorder. A person receiving treatment or assessment for a mental disorder can still be detained under the DOLS in hospital but only if the deprivation of liberty is only for the purpose of enabling a physical treatment unconnected, in terms of treatment defined in the Mental Health Act 1983, to the mental disorder and the treatment or assessment for the mental disorder could occur without a deprivation of liberty, if it was not for the physical condition.

If it is determined that a person is deprived of their liberty for the purpose of treatment as defined by the Mental Health Act 1983 and they object to a component of that care then the Mental health Act 1983 must be used.

### 3.13.22 **Determining if a Person objects**

Paragraph 5(6) and 5(7) of schedule 1A identifies what should be considered in determining if there is an objection:

In determining whether or not P objects to something, regard must be had to all the circumstances (so far as they are reasonably ascertainable), including the following—

- (a) P's behaviour;
- (b) P's wishes and feelings;

(c)P's views, beliefs and values.

But regard is to be had to circumstances from the past only so far as it is still appropriate to have regard to them.

Paragraph 5(4) of schedule 1A sets out what the decision makers have to decide there is an objection to or not:

- (a) to being a mental health patient, or
- (b) to being given some or all of the mental health treatment.

The Judge in GJ identified that this test cannot be applied without considering what the purpose of the care regime is. In considering how to interpret paragraph 5(4) He stated it (italics is my entry):has to be looked at in this way [*considering the purpose of the regime*] and without taking any fine distinctions between the potential reasons for the objection to treatment of different types, or to simply being in a hospital. As is recognised and provided for by paragraph 5(6), this is because it is often going to be the case that the relevant person (P) does not have the capacity to make a properly informed and balanced decision. So what matters, applying the approach set out in paragraph 5(6), is whether P will or does object to what is proposed. (paragraph 83)

In summary then, the purpose of the care regime that the detention is needed for should be identified. The decision maker must then consider the person's behaviour, wishes and feelings, views beliefs and values (including those of the past as far as it is still appropriate to) and if there is anything that could be considered an objection it should be considered as an objection to the regime as a whole and the person will be ineligible for DOLS, the Mental Health Act 1983 having primacy.

If a person in these circumstances does not object then a decision has to be made about which statute to use. Service level guidance is issued to cover these cases.

### 3.13.23 Action to be taken if a deprivation of liberty is occurring or is likely to occur.

Appendix 6 offers a step by step guide for when there are concerns a person who lacks capacity may be deprived of their liberty.

**The DOLS office that should be contacted will depend on where the person was ordinarily resident before the admission. Whichever supervisory body is contacted a copy of any urgent authorisation or referral for a standard authorisation needs to be faxed or emailed to the Quality and Risk team. This will be monitored and reported to the quarterly Deprivation of Liberty Governance group.**

Once a request for a standard authorisation has been made the supervisory body (the DOLS office) will arrange for a medical assessor and a Best Interest Assessor to complete the six required assessments: best interest assessment, age assessment, mental health assessment, eligibility assessment, capacity assessment, no refusals assessment. Only if all six assessments are positive will a DOLS be authorised.

If Solent NHS Trust staff are concerned that a deprivation of liberty is or is likely to be occurring in a Trust hospital or accommodation then the issue should be raised immediately with a registered professional or service manager; who should consider the issues, take appropriate steps in line with this policy and record their actions and reasons. If necessary this should include the care team considering what steps could be taken to prevent a deprivation of liberty.

If the care team believe a deprivation of liberty, is already occurring, cannot be avoided and the above criteria are met then Solent NHS Trust, as the managing authority, will need to make an urgent authorisation following the appropriate procedures. This will also involve making a request for a standard authorisation.

If the care team believe a deprivation of liberty is not yet occurring but is likely to occur, cannot be avoided and the criteria discussed above are met then Solent NHS Trust, as the managing authority, are responsible for referring for a standard authorisation in line with the appropriate procedures.

If there are concerns that a deprivation of liberty is occurring, the referral criteria for DOLS is not met, and provisions under the Mental Health Act 1983 cannot be used then immediate adjustments must be made to the care plan to stop the restrictions amounting to a deprivation of liberty. If there are any doubts an urgent authorisation should be given and a standard referral made.

If an application is made for a standard notification then the CQC will need to be informed when it is made and informed if it is approved. The Mental Health Act Administration team will undertake this task.

<http://www.cqc.org.uk/guidanceforprofessionals/nhstrusts/registration/notifications>.

Solent NHS Trust delegates their responsibilities as described in the table below.

| <b>Solent NHS Trust duty</b>   | <b>Band of staff from the ward responsible for undertaking this function</b>   |
|--|--|
| Care planning and delivering care in line with the Mental Capacity Act 2005.   | All staff in their clinical practice and clinical management of others are responsible for discharging this duty.  |
| Identifying where a deprivation of liberty is occurring or may occur.  | All staff, in their clinical practice and clinical management of others, are responsible for raising any concerns with regard to this duty.  |
|  | Any concerns should be raised with a ward staff member that is a registered health or social care professional. They should consider the issue, take appropriate action in line with this policy and clearly record their action and reasons. This should include considerations of the issues by the care team. |
| To submit DOLS applications to the Supervisory Body when a deprivation of liberty or a potential deprivation of liberty has been identified, only the designated Managing Authority may do this. COPIES must be sent to the Corporate Quality and Risk team. | Registered health or social care professional staff are responsible for discharging this duty.   |
| To inform the CQC when an application is made and to inform them if it is approved.  | The Mental Health Act Administration Team.   |
| To grant DOLS Urgent Authorisations when these are required, only the designated Managing Authority may do this.   | Registered health or social care professional ward staff are responsible for discharging this duty.  |
| To notify the patient and their families when Urgent Authorisations or Standard Applications have been submitted   | The staff member making the authorisation or referral is responsible for ensuring this duty is met. In some cases they can delegate this to another registered health or social Care staff member but they retain overall responsibility for ensuring the duty is discharged.                                    |

|  |  |
|--|--|
| To comply with Conditions set as part of the granting of a Standard Authorisation and to monitor the relevance of these conditions   | All staff at their level of practice must be aware of the conditions and ensure their intervention complies with them.<br>Registered health and social care staff from the ward, in their clinical management of the patient, are responsible for taking an overview of the case and ensuring this duty is met.<br>Medical staff in their clinical management of the patient are responsible for ensuring this duty is met.                            |
| To ensure the DOLS Relevant Person's Representatives are enabled to maintain reasonable contact with the patient, that their role is explained to them and their contact is monitored. | All staff are responsible to enable this appropriate to their role.<br>Registered health or social care professional staff from the ward are responsible for taking an overview and ensuring this duty is discharged.  |
| To monitor the care plan to see that the six qualifying requirements for a DOLS authorisation are still met  | All staff are responsible for being aware of the requirements and to raise concerns if any of the requirements appear not to be met.<br>These concerns should be raised with registered health or social care staff from the ward who are responsible for considering the situation, taking appropriate action in line with this policy and recording the action and their reasons. This should include considerations of the issues by the care team. |
| To report any significant changes, including no longer meeting any of the qualifying requirements or ending of the DOLS, to the Supervisory Body, to request a DOLS review.            | Registered health or social care staff from the ward are responsible for discharging this duty. They must contact the appropriate DOLS office and clearly record this action.  |

If Solent NHS Trust staff are concerned that an unauthorised deprivation of liberty is occurring or is likely to occur in non-trust accommodation then they should discuss their concerns with the managing authority of the home or hospital and with their line manager as soon as is practicable. If the situation has not been resolved the Trust Mental Capacity Act Lead should be consulted and the guidance in Chapter 9 of DOLS Code of Practice and in the Trust and Social Services Joint Procedures followed.

### 3.13.24 Situations in which an authorisation application has not been completed by the Supervisory Body, within the statutory timescales

If an application is submitted to the Supervisory body but a decision is not reached within the statutory times scales then an update should be sought from the Supervisory Body and a copy of any correspondence kept on file. A risk incident should be raised. Updates should be sought on a fortnightly basis by the Mental Health Act Administration Team or in the event of the person experiencing distress as a result of the deprivation of liberty by the ward. If any of the following apply then further advice should be sought as soon as is possible.

- the person is experiencing harm due to the deprivation of liberty;
- the person objects to the deprivation of liberty;
- there is uncertainty as to what is in the person's best interest with regard to key aspects of their care;
- serious medical treatment is being proposed;
- there is dispute about the person's best interest;
- there is potential conflict with an apparent advance decision to refuse treatment or decision of an attorney;
- the person could be within the scope of the Mental Health Act; or

- there is any other reason why the decision should not wait.

In these cases clear advice should be obtained from the Mental Capacity Act Lead or legal team and an action plan recorded in the notes. A copy of this and the plan should be sent to the Quality Team to record with the DoLs register.

### **3.13.25 Deprivation of Liberty in other Care Settings**

A person can be deprived of their liberty in other care settings. If they are and are unable to consent to it then the deprivation of liberty will need to be authorised. This will normally be by an application to the Court of Protection by the Local Authority or Clinical Commissioning Group. It is the responsibility of Solent NHS Staff to ensure that the relevant authority is made aware of any concerns staff members, including Associate Hospital Managers and Non-Executive Directors, have that a person is deprived of their liberty and this is not authorised. This can include in a person's own home if there is a significant state involvement in the care.

### **3.14 Reporting Risk events**

The implementation of this policy is monitored, in part, through a consideration of risk events that occur involving situations where a person does not have capacity to consent to particular interventions. It is therefore essential that staff completed the various questions on risk reports regarding the service user's capacity to consent at the time of the event.

## **4. ROLES & RESPONSIBILITIES**

### **4.1 Staff Responsibilities**

4.1.1 Clinical Leaders (all professions) are responsible for ensuring that their teams discharge their responsibilities under the terms of the Act.

4.1.2 This policy applies to bank, locum, permanent and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), Non-Executive Directors, governors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, Agency workers, and other workers who are assigned to Solent NHS Trust.

All who come into contact with patients, their relatives and carers and the public are responsible for being aware of the requirements of the Act and their responsibilities under the terms of the Act.

4.1.3 The policy author is responsible for updating the guidelines in the light of any relevant legislation, case law or change in policy.

### **4.2 Internal documentation system**

4.2.1 Assessments of capacity to make important decisions will be recorded on the SOLENT NHS TRUST pro forma (APPENDIX 1). This will be saved on the electronic system following the process chart in appendix 1.

4.2.2 Important decisions made in the best interests of the patient will be recorded on the SOLENT NHS TRUST pro forma (APPENDIX 2), This will be saved on the electronic system following the process chart in appendix 1.

4.2.3 A copy of the IMCA referral form should be placed on the patient's file, or noted on the electronic system as a progress note.

- 4.2.4 If care plans are undertaken in a patient's best interest then they should include a clear statement concerning the patient's capacity and details of the assessment, how the care plan was decided in their best interest, the effect of any restrictions and how it will be reviewed.
- 4.2.5 If a person who lacks capacity to consent is admitted to a Solent NHS Trust inpatient unit, in their best interest, the form in APPENDIX 1A will be completed.

## **5. TRAINING**

- 5.1 All people listed in 4.1.2 who may be expected to support an individual in decision making or who may be making a decision on behalf of another using the 'best interests' principle should have undertaken training appropriate to their role. This training will be provided in conjunction with the Learning and Development team who will be providing administrative support.
- 5.2 A e-learning modules for DoLs and the Mental Capacity Act should be completed by all clinical staff, registered and unregistered, once every three years. This is level 1 training.
- 5.3 Level 2 training is provided as a part of the Mental Health and Law training. This is mandatory training for qualified staff within Adult Mental Health, and Older Persons Mental Health. It needs to be repeated three yearly. It is also open to all staff from these areas and also to staff from Substance Misuse and Learning Disability Services.
- 5.4 Level 3 training aimed at clinical staff will be provided through a days training. Staff will have to have attended level 1 training before applying for a place on the level 3 sessions. This training will investigate the Act in more detail and will include use of this policy as a tool. This is mandatory training for all clinical staff Band 5 and above from the adult mental health, substance misuse, learning disability, older persons mental health and all inpatient units. It needs to be completed three yearly.
- 5.5 There are no cost implications, as the training will be provided in-house.
- 5.6 The above requirements are reflected in the Learning and Development Training Needs Analysis Matrix.

## **6. EQUALITY & DIVERSITY AND MENTAL CAPACITY ACT**

An Impact Needs Requirements Assessment (INRA) has been completed for this policy and no significant adverse effects have been noted. As the policy relates to people lacking capacity making their own decisions wherever possible it contributes positively towards equality and inclusion. (Appendix 13) This policy has been assessed and meets the requirements of the Mental Capacity Act 2005.

## **7. SUCCESS CRITERIA / MONITORING THE EFFECTIVENESS OF THE DOCUMENT**

- 7.1 It is the responsibility of each service line to assure itself it has adequate processes in place to monitor the implementation of the Mental Capacity Act. The Mental Capacity Act Lead in Adult Mental Health can offer advice and support but does not perform a governance function for the Mental Capacity Act, outside of Adult Mental Health. It should be clear in each service line who has responsibility for the governance of the Mental Capacity Act and how it will be monitored.
- 7.2 Various implementation tools have been produced by the Mental Capacity Act Lead to enable the Act to be monitored. It is up to each service lines to determine how to most effectively use them.
- 7.3 The Deprivation of Liberty Safeguards will be monitored by the Deprivation of Liberty Safeguards Governance group. Each inpatient unit will complete a quarterly audit and submit it to this group.

## **8. REVIEW**

This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed three years from initial approval and thereafter every three years unless organisational changes, legislation, guidance, or non-compliance prompt an earlier review.

## 9. REFERENCES AND LINKS TO OTHER DOCUMENTS

Dept of Health 2005 The Mental Capacity Act 2005 London, TSO on:  
[www.opsi.gov.uk/acts/acts2005/ukpga\\_20050009\\_en\\_1](http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1)

Dept of Health 2007 The Mental Capacity Act 2005 Code of Practice London, TSO on:  
[www.publicguardian.gov.uk](http://www.publicguardian.gov.uk)

Office of the Public Guardian [www.publicguardian.gov.uk](http://www.publicguardian.gov.uk)  
Tel: 0845 330 2900

Portsmouth City Council and Portsmouth Teaching PCT Joint Deprivation of Liberty Safeguards Procedures,

### Other Resources

Department of Constitutional Affairs leaflets on the Act

The British Psychological Society (April 2006) Assessment of Capacity in Adults: Interim Guidance for Psychologists, available from

The British Psychological Society: Best Interests Guidance on adults who lack capacity to make decisions for themselves [England and Wales] available from

Mind information on The Capacity Act 2005

Rethink information on The Capacity Act 2005

| <b>Appendices</b> |   |
|-------------------|---|
| Appendix 1A-      | Assessment of Capacity form   |
| Appendix 1B-      | Hospital admission and Capacity Form                                  |
| Appendix 2-       | Best Interests form   |
| Appendix 3-       | Referring to an IMCA  |
| Appendix 4-       | Guidance on establishing a best interest meeting                      |
| Appendix 5-       | Flowchart: Decision making when there are concerns regarding capacity |
| Appendix 6-       | Auditing standard   |
| Appendix 7-       | Equality and HR and MCA Impact Assessment                             |

**Mental Capacity Assessment Form 1**

**Mental Capacity Assessment under the Mental Capacity Act 2005**

|                                 |  |
|---------------------------------|--|
| <b>Name of patient</b>          |  |
| <b>DOB</b>                      |  |
| <b>Address</b>                  |  |
| <b>Date of Assessment</b>       |  |
| <b>Patient reference number</b> |  |

Please refer to the Trust policy, Deprivation of Liberty and Mental Capacity Act when completing this assessment.

|  |  |    |             |
|--|--|----|-------------|
| <b>Decision to be made</b>   |  |    |             |
| <b>What information does the person need to understand to make this decision</b>   |  |    |             |
| Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? | YES  | NO | FLUCTUATING |
|  | Comment:<br>If the answer is 'no' then the person has capacity |    |             |

|  |                              |
|--|------------------------------|
|  |                              |
| Does the impairment or disturbance mean that they are unable to complete the following four tests? If the person's ability to undertake these is fluctuating then the nature and degree of this should be described.   |                              |
| Can they understand the information about the decision to be made? Explain what they could not understand.   | YES      NO      FLUCTUATING |
|  | Comment:                     |
| Can they retain that information long enough to make the specific decision?  | YES      NO      FLUCTUATING |
|  | Comment:                     |
| Can they use or weigh that information as part of the decision-making process? This involves understanding the consequences of the decision. Explain what they could or could not understand.  | YES      NO      FLUCTUATING |
|  | Comment:                     |
| Are they able to communicate their decision?<br>Communication can be any means by which they make themselves understood. (talking, pictures, using sign language, gestures and body language). Only a small number of people will not be able to communicate by any means. | YES      NO      FLUCTUATING |
|  | Comment:                     |
| If any of the above are answered 'no' or 'fluctuating' can changes be made to the person's care to enable them to have capacity to make the decision? If so what is the plan if not explain why.   |                              |
| If the person lacks capacity are they likely to regain capacity and if so can the decision wait? If not say why  |                              |
| Did the person have any needs related to communication and how were these addressed? Please refer to separate assessments/ plans if appropriate (i.e. my plan, speech and language assessments) etc  |                              |
| Does the person have capacity to make this specific decision?  | YES      NO      FLUCTUATING |
| Reasons for this conclusion: (If capacity is fluctuating this must refer to the plan to address and review this. This should include if the decision can be made when they have capacity and how their views expressed, at the time they have capacity, will be recorded). |                              |
| Time and date of assessment  |                              |

|                     |                        |                 |
|---------------------|------------------------|-----------------|
| Place of assessment |                        |                 |
| Persons consulted:  |                        |                 |
| Name                | Relationship to person | Contact details |
|                     |                        |                 |
|                     |                        |                 |
|                     |                        |                 |

|  | Name | Job title | Signature |
|--|------|-----------|-----------|
| Person directing the intervention:           |      |           |           |
| Person undertaking assessment (if different) |      |           |           |



Appendix 1B

**THE MENTAL CAPACITY ALONE CAN NOT AUTHORISE DETENTION. TO PRACTICE AS SO IS TO ACT UNLAWFULLY**

**Assessment of Capacity Re: Admission to an inpatient Unit**

|   |  |                   |  |
|---|--|-------------------|--|
| <b>Name</b>                                   |  |                   |  |
| <b>DOB</b>                                    |  | <b>NHS Number</b> |  |
| <b>Date of Assessment</b>                     |  |                   |  |
| <b>Names of people involved in assessment</b> |  |                   |  |

|   |                           |    |
|---|---------------------------|----|
| 1) Is there an impairment of, or disturbance in, the functioning of the person's mind or brain? | YES                       | NO |
|   | If so, give details?..... |    |
| 2) Can the person:  |                           |    |
| a) Understand the information relevant to the admission?  | YES                       | NO |
| b) Retain that information long enough to decide?   | YES                       | NO |
| c) Use or weigh that information as part of the process of making the decision?                 | YES                       | NO |
| d) Communicate their decision?  | YES                       | NO |

Summary of key points in above assessment and what steps were taken to promote capacity?

**Authority to admit (one of these must be circled)**

**Informal patients**

Has capacity and consents

**Patients for whom DOLS must be used**

Lacks capacity to consent and admission amounts to a deprivation of liberty for the purpose of solely treating a physical disorder

Lacks capacity to consent and admission amounts to a deprivation of liberty for the purpose of treating a mental disorder but the person does not object to any aspect.

**Patients for whom MHA must be used**

Has capacity but refuses to consent or consent not reliable

Lacks capacity, is deprived of liberty for the purpose of treating, in whole or part, a mental disorder and objects/ non-compliant with any part of the regime

**Brief reason why the person is/ is not deprived of their liberty and this cannot be avoided**

(This must be completed for patients who lack capacity)

**Appendix 2**



**Best Interest Assessment Form**

**Deciding on a patient's Best Interest under The Mental Capacity Act, 2005**

(Please ensure the assessment of capacity form has been completed prior to commencing this form).

|   |  |
|---|--|
| <b>Name of service user/ patient</b>  |  |
| <b>DOB</b>  |  |
| <b>Details of the decision</b>  |  |
| <b>Is this being completed via an MDT meeting?</b>                            |  |
| <b>Is a best interest meeting needed?</b>                                     |  |
| <b>If this is a safeguarding issue has an appropriate referral been made?</b> |  |
| <b>Is an IMCA referral needed?</b>  |  |
| <b>Is there a valid and applicable advance decision covering this area?</b>   |  |
| <b>Is there a valid lasting power of</b>                                      |  |

|  |                               |   |                                  |                               |
|--|-------------------------------|---|----------------------------------|-------------------------------|
| <b>attorney or court appointed deputy?<br/>If so give details.</b>   |                               |   |                                  |                               |
| <b>Form completed by</b>   |                               |   |                                  |                               |
| <b>Date of completion</b>  |                               |   |                                  |                               |
| <b>Regaining of capacity</b> (Is it likely that the person will at some time have capacity in relation to the matter in question? If so, when is it likely to be? Can the decision wait till then? If the answer is yes then wait until capacity has been regained and then proceed with a consent form)<br>Details: |                               |   |                                  |                               |
| <b>Confirm you have followed the Best interest checklist</b>   |                               | Yes   |                                  | No                            |
| <b>How was the person encouraged to participate and how where their wishes and feelings established?</b>   |                               |   |                                  |                               |
| <b>What are the person's views, wishes and feelings both past and present, what weight should they be given and why?</b>   |                               |   |                                  |                               |
| <b>Who else in the person's social network have you consulted, what are their views, what weight should be given to them and why?</b>  |                               |   |                                  |                               |
| <b>Person</b>  | <b>Relationship</b>           | <b>View, weight to be given to it and why</b> |                                  |                               |
|  |                               |   |                                  |                               |
|  |                               |   |                                  |                               |
|  |                               |   |                                  |                               |
|  |                               |   |                                  |                               |
|  |                               |   |                                  |                               |
| <b>What are the relevant circumstances in this case. List the factors to be considered, the weight to be given to each and why.</b>  |                               |   |                                  |                               |
| <b>Circumstance</b>  |                               | <b>Weight to be given to it and why</b>       |                                  |                               |
|  |                               |   |                                  |                               |
|  |                               |   |                                  |                               |
|  |                               |   |                                  |                               |
| <b>What are the possible courses of action and likely outcomes. Include the effects of any restrictions that will be on the person and the effect/impact of NOT taking the course of action.</b>   |                               |   |                                  |                               |
| <b>Course of action</b>  | <b>Positives of following</b> | <b>Likelihood of positive</b>                 | <b>Negatives of following it</b> | <b>Likelihood of negative</b> |

|  |           |                  |  |                  |
|--|-----------|------------------|--|------------------|
|  | <b>it</b> | <b>occurring</b> |  | <b>occurring</b> |
|  |           |                  |  |                  |
|  |           |                  |  |                  |
|  |           |                  |  |                  |

**Weighing the above in the balance what is in the person's best interest and why. Include why and how it is the less restrictive intervention possible.**

**What restrictions on the person will be involved in the implementation of this plan and how are they proportionate to the seriousness and likelihood of risk to the person they are used to prevent and how will they be reviewed?**

**If the plan involves change in residence or admission to hospital does the cumulative effect of the restrictions amount to a Deprivation of liberty?                      YES                      NO**

If the answer is yes the DOLS procedures need to be followed

To be signed by those involved in the process.

| <b>Name</b> | <b>Role</b>           | <b>Signature</b> |
|-------------|-----------------------|------------------|
|             | <b>Decision maker</b> |                  |
|             |                       |                  |
|             |                       |                  |
|             |                       |                  |
|             |                       |                  |

## Referring to an Independent Mental Capacity Advocate (IMCA)

The following criteria must apply:

The patient must be eligible for an advocate under the MCA: (IMCA's do not provide general advocacy)

- Lack capacity (as assessed using the above guidance)
- Be 'unbefriended' i.e. there is no one available with whom it is appropriate to consult regarding the patient's wishes.

The patient must be in need of advocacy for one of the following reasons

- For serious medical treatment
- For NHS organised changes of residence lasting over 28 days (including hospital stays).
- For local authority organised changes of residence lasting over 8 weeks

An IMCA *may* be instructed to support someone who lacks capacity to make decisions concerning:

- care reviews, where no-one else is available to be consulted
- adult protection cases, whether or not family, friends or others are involved

You will be required to fill in a referral form, which will be provided to you by the IMCA

service or can be downloaded from [www.seap.org.uk](http://www.seap.org.uk).

The IMCA will visit and spend some time with the person who needs to make the decision. They may need to visit more than once, and it is important that the decision-maker communicates the exact nature and urgency of the decision in order that they can work effectively. They will then give an opinion to the decision maker.

The Portsmouth IMCA service is run by Solent Mind. Information about referrals can be found on their website:

<http://www.solentmind.org.uk/content/portsmouth-advocacy>

Phone 023 8020 8955

For patients resident in Southampton the IMCA service can be referred to by phoning 023 8020 8951, emailing [info@hampshireadvocacy.org.uk](mailto:info@hampshireadvocacy.org.uk) or via their website:

<http://www.solentmind.org.uk/content/mental-health-advocacy-and-imca-hampshire>

If you believe a patient is eligible and in need you are legally required to contact the IMCA service.

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## Guidance on organising a best interest meeting

- 1) A best interest meeting is called in consultation with the case holding clinician and their manager. In the most serious of cases this may involve senior managers from the organisation. Other services are requested to provide appropriate representation.
- 2) If it has not already been agreed, then at the meeting, it will be agreed which service will be the lead and take on the chairing role.
- 3) The best interest meeting must ensure itself that it is satisfied with the capacity assessments each agency and individual is responsible for bringing to it.
- 4) The group is responsible for following a 'best interest' decision making process. This includes; involving the patient and family and deciding on the weight to be given to their views, ensuring that any restrictions on the patient are necessary and proportionate to the likelihood and seriousness of harm they are at risk of and that there is appropriate authorisation for any intrusive or coercive acts with regard to the service user and or family. The chair is responsible for ensuring that the proper process is followed and this is clearly recorded.
- 5) The meeting is then responsible for agreeing any further delegation of responsibility in terms of formulating, enacting, monitoring and reporting on the best interest plan.
- 6) Certain functions can be brought to the group for advice but not delegated. For example, IMCA responsibilities, applying for DOLS authorisations, applications to the court of protection.
- 7) The group must agree time scales in which it will meet to review its plans. This should continue until it is agreed by the group that it no longer needs to meet.
- 8) If safeguarding is involved, the meeting must agree its relationship to the safeguarding process. This should include how the safeguarding meeting will be kept informed, and how and when further safeguarding meetings will be called, if none are planned. This will depend on how the safeguarding team are represented in the best interest meeting, the nature and degree of concerns and their likely resolution.

# Best Interest Meetings

## Introduction

When a person lacks the mental capacity to make a specific decision at a specific time then a 'decision maker' has to decide what is in their best interest. Who the decision maker is will depend on the decision to be made; it could be an informal carer or a professional. If there is an attorney (under a lasting power of attorney) or a court appointed deputy, who has the authority to make the decision or consent to the intervention, then they will be the decision maker; if not, it is the person who is directing the intervention. What the person has to consider and who they have to consult is set out in section 4 of the Mental Capacity Act 2005. If it is a significant decision then their duties can be discharged through a meeting. The meeting can also offer them support in making the decision.

Whenever any meeting is making decisions on behalf of a person who lacks capacity to make the specific decision at that time then the decision maker will need to be identified and they will need to ensure that the process followed in making the decision meets the requirements of the Mental Capacity Act. Following this guidance will ensure this. The leaflet may be helpful for any meeting where a decision is being made for a person who lacks capacity to make it.

For further information see the Deprivation of Liberty and Mental Capacity Act policy on the Solent NHS Trust policies intranet page.

## Planning the meeting

**Decisions to be made:** Ensure that these are best interest decisions that can be made under the Act<sup>4</sup> and that they are not ones a court has to make<sup>5</sup>. Do they or are they likely to involve a deprivation of liberty? What are the decisions? Who are the decision makers?

**Capacity Assessment:** Who is responsible for the capacity assessment or assessments?

**Involving the person and interested parties:** How is the person to be involved? How are their wishes and feelings to be represented? In particular:

*S4(6)*

*(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity);*

*(b) the beliefs and values that would be likely to influence his decision if he had capacity;*  
*and*

*(c) the other factors that he would be likely to consider if he were able to do so.*

Who else is to be involved in the meeting? In particular:

*S4 (7)*

*(a) anyone named by the person is someone to be consulted on the matter in question or on matters of that kind;*

*(b) anyone engaged in caring for the person or interested in his welfare; (c) any done of a power of attorney granted by the person;*

*(d) any deputy appointed for the person by the Court;*  
*as to what would be in the person's best interests*

Will the person attend all the meeting or only part? Do they need an advocate or supporter? If they will not attend how will their views be identified and represented? How will the group remain mindful of their views, wishes and feelings?

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<sup>4</sup> Deprivation of Liberty and Mental Capacity Act Policy, paragraph 3

<sup>5</sup> Deprivation of Liberty and Mental Capacity Act Policy. Paragraph 3.10

**Safeguarding:** Are there any safeguarding issues and how do they affect the way the meeting is to be structured. Are issues that must be addressed or information that cannot be discussed? Is there a dispute with the family? What steps have or can be taken to resolve this? Does it need to be brought before the Court of Protection?

**Chair and recording:** Who will chair the meeting? Who will minute the meeting and how will these be shared? Will the Best interest form be used to record the decision making process?

**Venue and process:** Where is the meeting to be held? Is this accessible by the person and family? Will the meeting be in two parts or one? Is there a need to have breaks in the meeting?

**Background to the decision:** Who will brief the meeting of the person's background, the context and the decision to be made? How will they ensure the person's understanding, wishes and feelings are represented?

**Invitations:** These should include a leaflet explaining best interest meetings.

## Meeting Agenda

**The starting point is the person's views, wishes and feelings. The agenda should therefore be flexible to allow them to appropriately share these with the group. Before the meeting starts it should be clear how this will be done.**

- 1) **Introduction.** Introductions. Remind the group:
  - a. *of the decision to be made*
  - b. *of the five statutory principles*
  - c. *the duties under the MCA and article 8 to fully involve the person the decision is about: taking into account their views as much as is possible, safe and practicable. That these views are important but not binding. That the process of how these views are considered and how the decision will be carried out is as important as the decision made,*
  - d. *that the meeting will take into account these and professionals views, identify the relevant circumstances, consider the positives and negatives of each, then decide which one is in the person's best interest and the least restrictive way to carry it out.*
  - e. *Finally, the group will agree a practical plan of who does what, a contingency plan and if and when further meetings are required.*
- 2) **Capacity Assessments:** Confirm that capacity assessments have been completed for the specific issues and who is responsible for them. Confirm who the decision makers are.
- 3) **Background:** A group member gives a background to the person, the decision to be made and its context. This should include a brief history of the person, any diagnosis, prognosis, the reason for the decision, what has already been tried, any current plans, the person's view on these, any areas of disagreement and any safeguarding issues that need to be addressed.
- 4) **Possible options:** The chair should ask the group to identify the possible options. These should be recorded.
- 5) **Family and person's views:** The family should be invited to give their views and wishes, if they have not already done so. The group should be reminded of the person's views, wishes and feelings.
- 6) **Group update and views:** Each person should give their understanding of the context, decision and issues to be considered, from their perspective.
- 7) **Discussion:** The chair should ask the group to identify the positive and negatives of each option and the relevant importance of the pros and cons of each option. These should be recorded.
- 8) **Decision:** The group should decide what the 'best interest' option is. The reason for the decision should be recorded; in particular:
  - a. *If the proposed option entails risks or disadvantages to P, reasons why these are thought to be outweighed and steps to be taken to minimise them*
  - b. *Any form of restraint involved should be identified and it recorded how this is proportionate to the likelihood and seriousness of harm it is seeking to prevent and how it will be kept to a minimum.*
  - c. *It should be recorded if anything in the plan indicates a deprivation of liberty or the involvement of the court will be needed to resolve a dispute or determine an issue only it has the authority to; if none of these are relevant, this should be recorded.*
  - d. *A contingency plan if the option does not succeed.*
- 9) **The Plan:** The practicalities of how the plan will be carried out should be agreed: by when, by whom, in what way and how these arrangements will be reviewed. If disagreement that will undermine the plan being carried out still exists then the chair should identify the next steps to resolve this or if legal advice is needed regarding bringing the matter before the court.

# CONFIDENTIAL

## Best Interests Meeting minutes

Meeting name: XXXXXXXX Best Interest Meeting

The meeting was held on: XXXXXXXXXX

Present: XXXXXX Apologies:

| Item No. | Item Minutes              | Action by:      |
|----------|---------------------------|-----------------|
| 1.       | <b>Introductions made</b> | <i>initials</i> |

2. **Explanation of the process:**

In 2005 the Mental Capacity Act was passed. It is designed to promote the rights of those who don't have the capacity, or ability, to make decisions for themselves. This meeting is a formal meeting and will be held in line with the Mental Capacity Act.

The Act has five guiding principles that have to be followed in all decision making:

- **A person must be assumed to have capacity unless it is established that they lack capacity.**
- **A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.**
- **A person is not to be treated as unable to make a decision merely because they makes an unwise decision.**
- **An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.**
- **Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.**

The Mental Capacity Act 2005 states that we have to presume that everyone has the capacity to make a decision unless we believe this is not the case. We are then duty bound to assess this. If the assessment concludes the person does not have the capacity we have to act in their best interests.

When assessing capacity we have to ask:

- **Do they have an impairment of the mind or brain affecting the way they make decisions?**

Is so:

- **Does the person who seems to lack capacity have a general understanding of the decision to be made?**
- **Do they have a general understanding of the consequence of this decision?**
- **Can they remember the information long enough to make a decision?**
- **Can they weigh up this information and use it to make a decision?**
- **Can they communicate the decision? This**

includes asking:

- **Is there any way that they could be helped to make the decision for themselves?**
- **Can they be helped to communicate their decision or their wishes and feelings?**
- **Is the person likely to regain capacity and if so can the decision wait?**

Because someone lacks capacity for one decision does not mean they lack the capacity for another decision. This meeting will therefore have to clarify the decisions or decisions to be considered.

At the same time just because a person expresses a wish does not mean to say they have the capacity to make a decision. However, if someone does not have capacity we do still have to listen to their wishes. Although not binding, their wishes should be given more weight the more consistent and persistent the person is about them and the more they understand the issues. They should also be built into the care plan as much as is sensible and practical.

To ensure the right decision is made on behalf of someone we need to gather those who know the person best and work through a clear and transparent process.

In making a decision we are bound by The Human Rights Act 1998 to act in a way compatible with people's rights under the European Convention of Human Rights. In particular we need to ensure our decisions support:

- **Article 5 – the right to liberty and security**
- **Article 8 – the right to respect for private and family life.**

In addition, the Mental Capacity Act in s4 sets out certain factors that have to be considered as far as is practicable. These are

*S4(6)*

*(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity);*

*(b) the beliefs and values that would be likely to influence his decision if he had capacity;*

*and*

*(c) the other factors that he would be likely to consider if he were able to do so.*



6. **Possible Options:**

*PLEASE LIST THE ALTERNATIVES THAT ARE AVAILABLE (e.g. to remain in house A, or, to move to house B, or, to move to house C, or, to find alternative placement. OR. To have a blood test under restraint, or, to have blood test under a GA, or, to not have a blood test)*

7. **Wishes and feelings of the person and how they were involved in the process:**

8. **Group members views and perspectives:**

Is an IMCA involved?

Name .....

The key elements of the decision to be made that are most significant are:

Please identify which elements are the most significant i.e. when choosing housing options it may be 1) closeness to family 2) ability to continue at same day service 3) staff are skilled at supporting people with ASC, etc.

XXXX

XXXX

XXXX

A balanced score card approach will be used to examine the options.

| <b>Positives</b>        | <b>Negatives</b> |
|-------------------------|------------------|
| <b>Option A; XXXXXX</b> |                  |
|                         |                  |
| <b>Option B: XXXXXX</b> |                  |
|                         |                  |

|                           |  |
|---------------------------|--|
| <b>Option etc: XXXXXX</b> |  |
|                           |  |

9. **Discussion of options and views:**

XXXXXXXXXXXXXXXXXXXX

**Does everyone agree with the decision being made?**

XXXXXXXXXXXX

If not, how will the disagreement be resolved?

If it cannot be, does the matter need to be brought to the Court of protection?

10. **Decision made:**

*N.B. THIS MAY BE THAT THE DECISION IS DEFERRED UNTIL FURTHER INFORMATION IS SOUGHT OR THAT A TEMPORARY DECISION IS MADE WITH A CLOSE REVIEW DATE*

If the proposed option entails risks or disadvantages to P, reasons why these are thought to be outweighed and steps to be taken to minimise them are:

11. **Plan of action:** The practicalities of how the plan will be carried out have been agreed:

| Action | By Whom | By when |
|--------|---------|---------|
|        |         |         |
|        |         |         |
|        |         |         |
|        |         |         |

Do the care arrangements amount to a deprivation of liberty and if so what steps are being taken to authorise this?

12. **Contingency plan**

13. **Review of decision:**

**Date set for:** XXXXXXXX

## **Deprivation of Liberty Safeguards/ Mental Health Act 1983**

Is any patient

**Under continuous supervision and  
control**

**And**

**Not free to leave**

It does not matter what their disability is,  
whether they object or are compliant or the  
reason for their care.

If so these factors should be considered as a part of care  
planning and steps taken to ensure the restrictions are  
proportionate and necessary. Steps should also be taken so  
they are free to leave or are not under continuous  
supervision and control or if this cannot be avoided the  
deprivation of liberty must be authorised.

---

## Audit Standards

Policy Title: **Decision making for people who lack mental capacity**

### Standard Statement

Staff will follow the principles of the Mental Capacity Act 2005 in dealings with people who have little or no capacity to make their own decisions.

### Criteria

1. All staff have completed basic training in The Mental Capacity Act 2005.
2. All clinical staff of Band 6 and Band 7 from Older Persons Mental Health, Adult Mental Health and Learning Disability services are up to date in completing their level 3 training in The Mental Capacity Act 2005 and all trained staff from Older Persons Mental Health and Adult Mental Health are up to date with level 2 training.
3. An assessment of capacity is undertaken and documented in the client file for important decisions where there were concerns regarding a person's capacity.
4. The appropriate decision maker was chosen and who this is clearly recorded.
5. The assessment of capacity clearly documents what steps were taken to enable capacity. (time of assessment, persons involved, communication needs considered).
6. Appropriate consultation with others occurred during the process of assessing capacity and this is clearly recorded.
7. Where a person lacked capacity a best interest assessment is completed and this is clearly recorded.
8. The best interest checklist has been considered and clearly recorded.
9. Referrals have been made to the Independent Mental Capacity Advocate service as required.
10. A copy of the patient's valid and applicable Advance Decision to Refuse Treatment is available in the case notes.
11. Details of Lasting Powers of Attorney are available in the case notes including contact details for the attorney, the type of LPA made (property and affairs or welfare) and the type of decision the attorney has power to make.
12. Any disputes concerning capacity or best interests have been resolved through following the guidance in this policy.

13. An application to the court of protection has been made for the relevant cases, as set out in this policy.
14. Where a person lacks capacity consideration has been given to ensure the care plan is as 'less restrictive' as possible.
15. When the patient lacks capacity and is receiving psychiatric treatment within a psychiatric hospital and restraint has been needed, use of The Mental Health Act 1983 has been considered.
  - a. It has been documented if the restraint was an indication of the person objecting to being in psychiatric hospital or the psychiatric treatment.
  - b. The reason for using or not using the provisions under The Mental Health Act 1983 has been recorded.
16. Where restrictions amount to or are likely to amount to a deprivation of liberty;
  - a. Steps have been taken to reduce this. If none can be taken this fact has been recorded.
  - b. When the patient is in a psychiatric hospital or when receiving psychiatric treatment consideration has been given to the use of the Mental Health Act 1983.
  - c. An urgent authorisation for a deprivation of liberty has been issued by the managing authority where necessary.
  - d. A referral has been made, where necessary, to the joint DOLS office for a standard authorisation of deprivation of liberty.

Decision Making Standard Outcome Measurement

This form is designed for the person responsible for monitoring the service standards. Any deficits in the standard must be reported to the person in charge so that corrective action can be taken. The standard will be monitored quarterly.

All staff have completed basic training in The Mental Capacity Act 2005.

Yes  No

All relevant staff are up to date in completing their level 3 training in The Mental Capacity Act 2005

Yes  No

An assessment of capacity is undertaken and documented in the client file for important decisions where there were concerns regarding a person's capacity.

Yes  No  N/A

The appropriate decision maker was chosen and who this is clearly recorded.

Yes  No  N/A

The assessment of capacity clearly documents what steps were taken to enable capacity. (time of assessment, persons involved, communication needs considered).

Yes  No  N/A

Appropriate consultation with others occurred during the process of assessing capacity and this is clearly recorded.

Yes  No  N/A

Where a person lacked capacity a best interest assessment is completed and this is clearly recorded.

Yes  No  N/A

The best interest checklist has been considered and clearly recorded.

Yes  No  N/A

Referrals have been made to the Independent Mental Capacity Advocate service as required.

Yes  No  N/A

A copy of the patient's valid and applicable Advance Decision to Refuse Treatment is available in the case notes.

Yes  No  N/A

Details of Lasting Powers of Attorney are available in the case notes including contact details for the attorney, the type of LPA made (property and affairs or welfare) and the type of decision the attorney has power to make.

Yes  No  N/A

Any disputes concerning capacity or best interests have been resolved through following the guidance in this policy.

Yes  No  N/A

An application to the court of protection has been made for the relevant cases, as set out in this policy.

Yes  No  N/A

Where a person lacks capacity consideration has been given to ensure the care plan is as 'less restrictive' as possible.

Yes  No  N/A

When the patient lacks capacity and is receiving psychiatric treatment within a psychiatric hospital and restraint has been needed, use of The Mental Health Act 1983 has been considered.

Yes  No  N/A

It has been documented if the restraint was an indication of the person objecting to being in psychiatric hospital or the psychiatric treatment.

Yes  No  N/A

The reason for using or not using the provisions under The Mental Health Act 1983 has been recorded.

Yes  No  N/A

Where restrictions amount to or are likely to amount to a deprivation of liberty;



## Equality & Human Rights and Mental Capacity Act Impact Assessment

| <b><u>Step 1 – Scoping; identify the policies aims</u></b>  | <b>Answer</b>  |
|---|--|
| 1. What are the main aims and objectives of the document?   | To ensure the organisation’s compliance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards  |
| 2. Who will be affected by it?  | All staff across the organisation and potentially all service users  |
| 3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve? | There is currently a consent audit and evidence for essential standards 2 and part of 7 (DOLS and restraint)   |
| 4. What information do you already have on the equality impact of this document?                              | National evidence on DOLS indicates that there is no significant difference to the way it is applied concerning Race or religion. It is applied more for older people and people with disabilities with mental disorder because its aim is to protect the human rights of those who lack capacity to agree to stay in a hospital or care home and are deprived of their liberty, and there are more of this group in the older population. There are also more females in this group. However, the policy ensures Article Rights are upheld for these groups. There has been 4 DOLS applications in Solent NHS Trust. There is nothing to suggest the local situation differs from the national one.<br>People’s rights under the MCA will be upheld by this policy. The principles of the policy and the capacity and best interest process ensure discrimination is not occurring in the process. This policy will set the standards and allow this to be monitored. |
| 5. Are there demographic changes or trends locally to be considered?  | Ensure there are suitable communication means for providing information to service user groups whose first language is not English or have other means of communicating.   |
| 6. What other information do you need?  | None   |

| <b><u>Step 2 - Assessing the Impact; consider the data and research</u></b>                  | <b>Yes</b> | <b>No</b> | <b>Answer<br/>(Evidence)</b>   |
|--|------------|-----------|--|
| 1. Could the document unlawfully against any group?  |            | no        | The document complies with the statute and ensures its compliance  |
| 2. Can any group benefit or be excluded?   | yes        |           | The document, if complied with, will ensure the rights are upheld for all those, and their carers, where there are concerns regarding their capacity about a specific issues at a specific time. |
| 3. Can any group be denied fair & equal access to or treatment as a result of this document? |            | no        | As above   |
| 4. Can this actively promote good relations with and between different groups?               | yes        |           | As above. There are also processes for dealing with disagreements and disputes, including the use of advocates and mediation.  |

|   |  |    |   |
|---|--|----|---|
| 5. Have you carried out any consultation internally/externally with relevant individual groups? |  | no | The MCA and its code of practice was developed in consultation with a wide variety of service user groups. The policy will be monitored via feedback from the |
|---|--|----|---|

|   |     |    |   |
|---|-----|----|---|
|   |     |    | patient experience service and risk events, which will be considered at the MCA and DOLS implementation group |
| 6. Have you used a variety of different methods of consultation/involvement   |     | no | See above   |
| Mental Capacity Act implications  | yes |    | Ensures organisation compliance with these  |
| 7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information) | yes |    | See above   |

If there is no negative impact – end the Impact Assessment here.

| <b>Step 3 - Recommendations and Action Plans</b>  | <b>Answer</b> |
|---|---------------|
| 1. Is the impact low, medium or high?   |               |
| 2. What action/modification needs to be taken to minimise or eliminate the negative impact? |               |
| 3. Are there likely to be different outcomes with any modifications? Explain these?         |               |

| <b>Step 4- Implementation, Monitoring and Review</b>   | <b>Answer</b> |
|--|---------------|
| 1. What are the implementation and monitoring arrangements, including timescales?                        |               |
| 2. Who within the Department/Team will be responsible for monitoring and regular review of the document? |               |

| <b>Step 5 - Publishing the Results</b>  | <b>Answer</b> |
|---|---------------|
| How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made). |               |